Healthcare Transformation Collaboratives Cover Sheet

An HFS Initiative
HTC Healthcare Transformation Collaboratives

1. Collaboration Name: Delta Region Care Coordination Collaborative

2. Name of Lead Entity: Illinois Critical Access Hospital Network

3. List All Collaboration Members:

Massac Memorial Hospital
Franklin Hospital District
MArshall Browning Hospital Association
Randolph Hospital District dba Memorial Hospital
Sparta Community Hospital District
Ferrel Hospital Community Foundation
Wabash General Hospital District
Hamilton Memorial Hospital District
Pinckneyville Community Hospital
ComWell
Carbondale Branch NAACP
Centerstone
Illinois Migrant Council

4. Proposed Coverage Area:

Edwards, Franklin, Hamilton, Jackson, Lawrence, Massac, Perry, Pope, Randolph, Saline, Wabash and White Counties.

5. Area of Focus:

Delta REACH is anchored in the region's unique needs and reflects research supporting the effectiveness of the CHW model in mitigating disparities and harnessing positive health outcomes in rural communities. Through Delta REACH, the DRCCC seeks to holistically increase access to care, address social determinants of health, and improve health equity for rural, Medicaid-eligible patients in the Delta Region.

6. Total Budget Requested: $14,914,564.00

Form 0: Eligiblity Screen

Does your collaboration include multiple external entities?
Yes

Can any of the entities in your collaboration bill Medicaid?
Yes

Form 1: Participating Entities

Entity Name	Tax ID #	Primary Contact	Position	Email	Office Phone	Secondary Contact	Position	Email
Massac Memorial Hospital	37-0857852	Lennis Thompson	CEO	lennist@ massachealth.org	618-524-2176	Lynn Goines	CFO	lgoines@ massachealth.org
Franklin Hospital District	37-6006885	Jim Johnson	CEO	Jim.johnson@ franklinhospital.net	618-435-9600	Rikki Bonthron	CFO	Rikki.bonthron@ franklinhospital.net
Marshall Browning Hospital Association	37-0661218	Larry Spour	COO	Larry.spour@ mbhdq.com	618-542-1089	Healther Kattenbraker	Executive Assistant	Healther.kattenbraker@ mbhdq.com
Randolph Hospital District dba Memorial Hospital	37-6020801	Brett Bollman	CEO	bbollmann@ mhchester.com	618-826-4581	Susan Diddlebock	CNO	sdiddlebock@ mhchester.com
Sparta Community Hospital District	37-6014817	Joann Emge	CEO	emgej@ spartahospital.com	618-443-1337	Paul Mueller	CFO	muellerp@ spartahospital.com
Ferrell Hospital Community Foundation	20-1244058	Alisa Coleman	CEO	acoleman@ ferrellhospital.org	618-297-9615	Rachael Prather	CNO	rprather@ ferrellhopsital.org
Wabash General Hospital District	37-6013625	Lynn Leek	CFO	lleek@ wabashgeneral.com	618-263-6375	Tamara Gould	COO	tgould@ wabachgeneral.com
Hamilton Memorial Hospital District	37-601-9589	Victoria Woodrow	CEO	vwoodrow@ hmhospital.org	618-643-2361	Jenee Wilson	Quality Director	jburchell@ hmhospital.org

Pinckneyville Community Hospital	37-6006955	Randall Dauby	CEO	rdauby@pvillehosp.org	618-357-5901	Kara Jo Carson	CFO	kjcarson@pvillehosp.org
ComWell	51-0137833	Shea Haury	Executive Director	shaury@comwell.us	618-282-6233	Kendra Kennedy	Director of Quality Assurance & Development	kkennedy@comwell.us
Carbondale Branch NAACP	80-0068686	Linda Flowers	President	carbondalebranchnaacp@gmail.com	618-319-6771	Stephanie Brown	Secretary	secretarycarbondalenaacp@gmail.com
Centerstone	37-0916475	John Markley	CEO	John.markley@centerstone.org	877-467-3123	Anne Tyree	COO	Anne.tyree@centerstone.org
Illinois Migrant Council	36-2597070	Magdalena Rivera	CEO	mrivera@illinoismigrant.org	815-995-0300	Esperanza Gonzalez	Operations Director	ecelasquez@illinoismigrant.org

Are there any primary or preventative care in your collaborative? Yes

a. **Please enter the names of those entities:**

- Marshall Browning Hospital Association
- Franklin Hospital District
- Massac Memorial Hospital
- Memorial Hospital
- Sparta Community Hospital District
- Ferrell Hospital
- Wabash General Hospital District
- Hamilton Memorial Hospital District
- Pinckneyville Community Hospital

- **Are there any specialty care providers in your collaborative?** Yes

a. **Please enter the names of those entities:**

- Marshall Browning Hospital Association
- Franklin Hospital District
- Massac Memorial Hospital
- Memorial Hospital
- Sparta Community Hospital District
- Ferrell Hospital
- Wabash General Hospital District
- Hamilton Memorial Hospital District
- Pinckneyville Community Hospital

- **Are there any hospital services providers in your collaborative?** Yes

a. **Please enter the name of the first hospital entity:**
Marshall Browning Hospital Association

b. **Which MCO networks does this hospital participate in:**

- YouthCare
- BCBS Community Health Plan
- IlliniCare Health
- Meridian Health Plan
- Molina Healthcare

c. **Please enter the name of the second hospital entity:**
Franklin Hospital District

d. **Which MCO networks does this hospital participate in (if applicable):**

- BCBS Community Health Plan
- IlliniCare Health
- Meridian Health Plan
- Molina Healthcare

e. **Please enter the name of the third hospital entity (If applicable):**
Massac Memorial Hospital

f. **Which MCO networks does this hospital participate in:**
- YouthCare
- BCBS Community Health Plan
- IlliniCare Health
- Meridian Health Plan
- Molina Healthcare

g. **Please enter the name of the fourth hospital entity (If applicable):**
Randolph Hospital District dba Memorial Hospital

h. **Which MCO networks does this hospital participate in:**
- YouthCare
- BCBS Community Health Plan
- IlliniCare Health
- Meridian Health Plan
- Molina Healthcare

i. **Please enter the name of the fifth hospital entity (If applicable):**
Sparta Community Hospital District

j. **Which MCO networks does this hospital participate in:**
- YouthCare
- BCBS Community Health Plan
- Meridian Health Plan
- Molina Healthcare

k. **Please enter the name of the sixth hospital entity (If applicable):**
Ferrell Hospital

l. **Which MCO networks does this hospital participate in:**
- YouthCare
- BCBS Community Health Plan
- IlliniCare Health
- Meridian Health Plan
- Molina Healthcare

m. **Please enter the name of the seventh hospital entity (If applicable):**
Wabash General Hospital District

n. **Which MCO networks does this hospital participate in:**
- BCBS Community Health Plan
- IlliniCare Health
- Meridian Health Plan

- Molina Healthcare

o. **Please enter the name of the eighth hospital entity (If applicable):**
Hamilton Memorial Hospital District

p. **Which MCO networks does this hospital participate in:**
- YouthCare
- BCBS Community Health Plan
- IlliniCare Health
- Meridian Health Plan
- Molina Healthcare

q. **Please enter the name of the ninth hospital entity (If applicable):**
Pinckneyville Community Hospital

r. **Which MCO networks does this hospital participate in:**
- YouthCare
- BCBS Community Health Plan
- IlliniCare Health
- Meridian Health Plan
- Molina Healthcare

- **Are there any mental health providers in your collaborative?** Yes
  a. **Please enter the names of entities:**
  Ferrell Hospital
  Wabash General Hospital District
  Hamilton Memorial Hospital
  ComWell
  Centerstone

- **Are there any substance use disorder services providers in your collaborative?** Yes
  a. **Please enter the names of entities:**
  Wabash General Hospital District
  ComWell
  Centerstone

- **Are there any social determinants of health services providers in your collaborative?** Y or N
  a. **Please enter the names of entities:**
  Wabash General Hospital District
  ComWell
  Carbondale NAACP

- **Are there any safety net or critical access hospitals in your collaborative?** Yes
  a. **Please enter the names:**
  - Marshall Browning Hospital Association

- Franklin Hospital District
- Massac Memorial Hospital
- Memorial Hospital
- Sparta Community Hospital District
- Ferrell Hospital
- Wabash General Hospital District
- Hamilton Memorial Hospital District
- Pinckneyville Community Hospital

- **Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majority controlled and managed by minorities?**
  a. Please list the. Names of entities:
  Carbondale NAACP
  Illinois Migrant Council

- **Please list the Medicaid-eligible billers in your collaborative and the Medicaid ID for each:**
  Memorial Hospital
  Marshall Browning Hospital
  Massac Memorial Hospital
  Franklin Hospital District
  Sparta Community Hospital District
  Ferrell Hospital
  Wabash General Hospital District
  Hamilton Memorial Hospital District
  Pinckneyville Community Hospital
  ComWell
  Centerstone

- **Check <u>all</u> of the project types below that apply to your project:**
  __ Safety Net Hospital Partnerships to Address Health Disparities
  __ Safety Net plus Larger Hospital Partnership to Increase Specialty care
  _X_ Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led by Critical Access Hospitals, Safety Net Hospital or other hospital in distressed communities)
  _X_ Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or Critical Area Hospitals as significant partners)
  __ Cross-Provider Care Partnerships led by Minority Providers, Vendors or Not-for-profit Organizations
  __ Workforce Development and Diversity Inclusion Collaborations
  __ Other

  a. If "Other," provider additional explanation here:

Form 2: Project Description

Brief Project Description

1. Provide an official name for your collaboration:

Delta Region Care Coordination Collaborative (DRCCC)

2. Provide a one to two sentence summary of your collaboration's overall goals:

The Delta Region Care Coordination Collaborative (DRCCC) represents the commitment of more than 14 diverse stakeholders, including 9 critical access hospitals (CAHs), and the support of multiple community based organizations (CBOs) to increase access to care and improve health outcomes among Medicaid-eligible populations in 12 rural counties in Southern Illinois. With particular focus on bringing longstanding racial/ethnic health inequity to the forefront of healthcare strategic planning, along with addressing the social determinants of health that exacerbate this inequity, Delta REACH will implement a community health worker (CHW) model of care to provide a culturally-competent intervention, establish new care coordination infrastructure at the local and regional levels to support closed-loop referrals and integrated care, and utilize technology to advance partners' abilities to analyze and improve population health outcomes.

Detailed Project Description: *Provide a narrative description of your overall project, explaining what makes it transformational. Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project.*

The Illinois Delta Region (IDR) spans 16 rural counties in Southern Illinois and exhibits a host of health disparities endemic to rural regions in the U.S., ranging from a severe shortage of qualified health care professionals to disproportionately poor health outcomes – staggeringly so for the racial and ethnic minority populations of the area. Although a number of safety net providers, organizations, and initiatives currently work to address residents' needs, available services and supports are deeply fragmented, thus leading to vulnerable populations "slipping through the cracks" and frequently seeking care in hospital emergency departments (EDs). This situation, though never ideal, is now untenable in the wake of the COVID-19 pandemic, when rural EDs are already overrun. According to Critical Access Hospitals (CAHs) serving the region, along with input from residents themselves, the most pervasive factor driving this situation is a lack of formal coordination of care.

The Illinois Critical Access Hospital Network (ICAHN) and nine of its CAHs are partnering together as the Delta Region Care Coordination Collaborative (DRCCC) to address this need in 12 of the IDR counties: Edwards, Franklin, Hamilton, Jackson, Lawrence, Massac, Perry, Pope, Randolph, Saline, Wabash, and White. This project represents an opportunity for HFS to support a targeted, scalable intervention in the state's most rural counties, whose residents demonstrate strikingly high rates of poverty, and whose racial/ethnic minority residents experience the long-term effects of a racially oppressive and segregated history. Drawing upon evidence-based best practices from community health worker (CHW) and care coordination models of care and leveraging health information technology (HIT), Delta REACH is anchored in the region's unique needs and reflects research supporting the effectiveness of the CHW model in mitigating disparities and harnessing positive health outcomes in rural communities. Through Delta REACH, the DRCCC seeks to holistically increase access to care, address social determinants of

health, and improve health equity for rural, Medicaid-eligible patients in the IDR. It is important to note that DRCCC members, including CAHs and CBOs, have a long history of executing programs and initiatives to meet the needs of their target populations; there is a wide range of health care services and community resources available in each county. Additionally, four of the CAHs (Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital, and Sparta Community Hospital) are in the final year of a three-year grant for the Delta Region Community Health Systems Development Project (DRCHSP), which aims to improve healthcare delivery in the Delta Region through technical assistance to healthcare facilities in rural communities. DRCHSP is a collaboration of the Health Resources and Services Administration (HRSA)'s Federal Office of Rural Health Policy (FORHP) and the Delta Regional Authority supporting capacity building for care coordination, as well as the creation of a "Community Champion" position to increase engagement with the local community. Although DRCHSP has promoted stronger collaboration between the 4 CAHs and their communities, much work remains to solidify infrastructure for the 4 CAHs and to extend this effort across the region. Moreover, DRCHSP's scope does not encompass this project's focus on Medicaid-eligible populations at risk for ED overutilization. Every ED sees patients every day who lack access to primary care, struggle to receive behavioral health support, and/or struggle to meet their basic needs. This project's transformative potential is rooted in its ability to serve as the "missing link" between the health and SDOH needs of the Delta Region's most vulnerable populations, along with the existing health care and community services capable of meeting them. Specific project goals include the following:

- Create a dynamic, culturally competent care coordination infrastructure at the local (CHW/Advanced Practice Registered Nurse (APRN) Care Team in each CAH ED connecting patients to healthcare and community-based services) and regional (Project Director overseeing relationships between Care Teams, providers, and CBOs across 12 counties) level that increases access to quality care, improves health outcomes, and reduces cost of care for rural Medicaid-eligible patients.
- Develop a technology platform that both animates and evaluates this care coordination infrastructure at the local and regional level, as well as supports standardized collection and sharing of population health data.
- Improve health equity through a regional approach to engaging diverse stakeholders and providing cultural competency training for healthcare providers and staff.
- Demonstrate the effectiveness of CHWs for increasing access to care, improving health outcomes, and reducing costs by conducting comprehensive process/outcome evaluation.
- Support increased patient access to telehealth services through systematized interventions.
- Advance advocacy for policy reform that would incorporate CHWs into billable services by exploring collaboration with public and private payers to develop alternative payment models (APMs) and pilot payment models.

These goals will be achieved through the following **key strategies:**

1. Completion of Needs Assessment and Gap Analysis: The Needs Assessment will not duplicate Community Health Needs Assessments (CHNAs), but will rather focus on establishing baseline data for relevant core measures, such as ED utilization, hospitalization, transfer, and discharge rates, along with primary care, specialty care, behavioral health, and SUD/OUD treatment referral rates. An inventory of existing health care providers and services will be

conducted, as well as community-based services, supports, and resources addressing SDOH. In addition, a gap analysis will be performed to analyze existing referral patterns and identify gaps in services. This analysis will inform the development of CHW and provider workflows, as well as the development of the database platform for tracking care coordination metrics. Both the Needs Assessment and Gap Analysis will be conducted by the Needs Assessment and Gap Analysis Subcommittee of the Steering Committee.

2. Implementation of a CHW model: Delta REACH will embed a CHW/APRN care team in each of the 9 CAH EDs, for a total of 9 CHW/APRN care teams across the service area. Within each care team, the CHW will directly interface with patients, while the APRN will: 1) provide clinical oversight; 2) make referrals to primary care physicians (PCPs) and specialists; 3) manage prescriptions; 4) provide case management, coaching, and support to the CHW; and 5) serve as a liaison to participating CBOs receiving patient referrals from the CHW and providing SDOH resources and services. Importantly, each CHW/APRN Care Team will hire one 1.0FTE CHW as well as one 0.4FTE CHW, with the goal of having a CHW available 7 days a week, including nights and weekends. This model draws upon components of the "Care Coordinator/Manager" and "Outreach and Enrollment Agent CHW" program models delineated by the Office of Rural Health's CHW Toolkit.[1] Moreover, this model adapts several core features of the St. Johnsbury Community Health Team Model, a project that achieved such transformative effects in rural Vermont that the CDC used it as an Implementation Guide for Public Health Practitioners.[2] It will also leverage the experience in community engagement and capacity for care coordination developed in the 4 CAHs that participated in the DRCHSP, while driving that work forward through a targeted approach for meeting the needs of Medicaid-eligible patients in the ED.

Recruitment, training, and supervision: CHWs will: 1) be recruited from the target population, 2) reflect target population demographics, 3) demonstrate minimum qualifications of Certified Medical Assistant (CMA) training and experience, and 4) exhibit unique familiarity with community culture, needs, and resources in keeping with the CDC CHW Toolkit's assertion that "the most important qualities of CHWs are their understanding of the community and their commitment to helping people in that community." CMA qualification will ensure CHWs have foundational knowledge and experience that will allow for rapid onboarding within the clinical (ED) environment and timely launch of the project. Project partners are confident in the existence of an adequate candidate pool to meet these qualifications. CHWs will receive intensive training through an existing CHW Training program offered by the Illinois Public Health Association (IPHA). This training program was developed in 2020 and has successfully trained 658 CHWs to date. IPHA's evidence-based curriculum is anchored in 12 core competencies (advocacy; communications; presentation and facilitation skills; organizational skills; cultural competency/humility; interpersonal and relationship-building skills; knowledge of major health systems of the body; behavioral health; public health; field experience) and requires a minimum of 40 hours of training. CHWs must pass a formal assessment of competency in order to complete the training. With regard to supervision, DRCCC designed the model to reflect the supervisory structure of effective CHW models, such as the St. Johnsbury Community Health Team Model, leveraging the ongoing supervision and support of clinicians. Given the fact that the target population will likely present with complex, interrelated medical conditions and

---

[1] Rural Health Information Hub. (nd). Community Health Worker Toolkit. https://www.ruralhealthinfo.org/toolkits/community-health-workers/2/program-models

[2] Centers for Disease Control and Prevention. Implementation Guide for Public Health Practitioners: The St. Johnsbury Community Health Team Model. Atlanta, GA: U.S. Dept of Health and Human Services; 2015.

SDOH issues, the ability of CHWs to immediately call upon the expertise and guidance of clinicians is key to project success. DRCCC plans to recruit and hire 9 APRNs, 1 for each care team. Aware of the possible challenges to recruiting this number of advanced practice providers, DRCCC plans to recruit licensed clinical providers (e.g., licensed clinical social workers) should the full number of APRNs prove difficult to recruit. Finally, DRCCC acknowledges that CHWs hired for this project will meet the criteria of having lived experience and a unique familiarity with the challenges experienced by the target population, and therefore may struggle themselves with SDOH and health issues or lasting impact of them. In order to ensure that the supervisory structure empowers CHWs, APRNs will receive training through an existing webinar series developed by ICAHN's professional education team. This training curriculum is anchored in the six guiding principles of a trauma-informed approach, which is defined by the Centers for Disease Control and Prevention as safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment and choice; and cultural, historical and gender issues. The curriculum also delves into adverse childhood experiences (ACEs) and their long-lasting effects on physical and behavioral health.

Through direct supervision and supportive mentoring (one-on-one meetings to review CHWs' progress and challenges), APRNs will ensure that CHWs have access to the support and resources necessary for them to perform well in a challenging position. CHWs will also have access to peer support through an ICAHN list serve that will be created specifically for CHWs, and through ongoing "wellness calls" hosted by IPHA to promote peer support among CHWs.
***Description of CHW workflow and patient engagement*:** As depicted in the attached **CHW workflow graphic**, all patients seen in the ED will complete a SDOH screening tool, CMS's The Accountable Health Communities Health-Related Social Needs Screening Tool,[3] designed for clinicians and their staff to use "as part of their busy clinical workflows with people of all different ages, backgrounds, and settings." The tool assesses patient needs across 13 domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs
- Interpersonal safety
- Financial strain
- Employment
- Family and community support
- Education
- Physical activity
- Substance use
- Mental Health
- Disabilities

The embedded CHWs will review results; CHWs will conduct additional screening for behavioral health, SUD, and OUD for patients with risk factors through the Screening, Brief

[3] Centers for Medicare and Medicaid Services. The Accountable Health Communities Health-Related Social Needs Screening Tool. https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Intervention and Referral to Treatment (SBIRT) tool. With results from the SDOH screening and, if applicable, the SBIRT, the CHW will utilize a standardized risk stratification tool, based on the American Academy of Family Physicians' Risk-Stratified Care Management Scoring Algorithm,[4] to assign patients a high, moderate, or low-risk level. This will inform CHWs' phased engagement with patients based on their level of need. CHWs will engage with each patient to perform a **situation assessment** to identify the problem and contributing factors. The situation assessment will utilize structured, standardized forms to capture similar elements and measures. Next, based upon shared decision making and available resources, CHW and patient will develop a **plan of resolution** incorporating known applicable resources, milestones, and a timeline. This design not only ensures a patient-centered approach, but also boosts evaluative efficacy, as the two items (situational assessment and plan of resolution) support directly comparable efforts resulting across partners and also allows for analysis of which efforts produce which results. The CHW will help the patient navigate the entirety of the plan of resolution, for example: enrollment in Medicaid, attending a telehealth appointment with a behavioral health provider, and obtaining transportation to a PCP appointment. CHWs, healthcare providers, and CBOs in a given community will input relevant data (such as referrals, enrollment in Medicaid, empanelment with a PCP, SUD/OUD treatment, registration for subsidized housing, etc.) into the technology platform (explained in detail below). APRNs will provide relevant support, coaching, guidance, and coordination; ensure smooth referral to community resources; and support the achievement of closed loop referrals. DRCCC will also guide the development of peer support among the CHWs, as this is a component of several successful CHW models, such as the Clinical-Community Health Worker Initiative in the Mississippi Delta[5] and the St. Johnsbury Community Health Team Model. A CHW list serve will be created, where CHWs can share questions, comments, and stories of their patient engagement with one another in service of sharing best practices and resources, along with building a network for camaraderie and support.

3. Creation of a regional approach to improving health equity: Systemic poverty and lack of education and employment opportunities drive health inequity across the entire IDR population. Moreover, as a region with relatively low representation of racial/ethnic minority populations, the IDR has historically lacked a comprehensive, unified strategy for addressing racial equity in public health. The death of George Floyd in June 2020 and ensuing protests brought racial equity to the forefront of regional conversation, which led to increased momentum in residents' ability to acknowledge and address the effects of structural racism across society. DRCCC plans to build upon this momentum by integrating a strong focus on cultural competency education and advocacy into the project. Although special attention will be paid to advancing anti-racist policies and approaches, consideration of the issues – closely tied to SDOH – undergirding health inequity across racial/ethnic lines will be key to this strategy. An Equity Coordinator will be hired to lead an Equity Subcommittee of diverse stakeholders across the region; work with the IPHA to ensure that CHW training curriculum embeds equity-driven knowledge and practices; and develop and deliver cultural competency education to the providers and staff of each of 9 CAHs. The Equity Coordinator will also leverage the expertise of Linda Flowers, the Executive Director of the Carbondale NAACP, as the Equity Subject Matter Expert in developing the cultural competency education for providers and staff.

---

[4] (5 May 2021). AAFP Tools Ease Patient Risk Stratification, Care Planning. https://www.aafp.org/news/practice-professional-issues/20210505rscmtools.html

[5] Centers for Disease Control and Prevention. (nd). Clinical-Community Health Worker Initiative: Field Notes. https://www.cdc.gov/dhdsp/docs/field_notes_clinical_community_health_worker.pdf

4. Development of a technology platform: Delta REACH will require the creation of a database that supports tracking key project metrics spanning health care and SDOH indicators, such as number of patients completing the SBIRT screening, number of patients receiving primary care referrals, number of patients with closed loop referrals for behavioral health services, number of eligible patients enrolled in Medicaid, number of patients receiving transportation assistance, etc. DRCCC proposes to work collaboratively with HFS to identify any existing resources or initiatives, such as HFS's current contract with Collective Medical that may support this strategy, creating a new system through REDCap, or producing a similar resource capable of supporting project goals. This platform will be accessible to both health care providers and staff as well as CBOs in local communities, therefore serving as a seminal improvement in the collaborative potential of healthcare and community resources.

5. Increase patient access to telehealth services: As **Form 6: Data Support** will describe, the target population has significantly lower rates of access to broadband internet as compared to the state and nation. With telehealth emerging as a key modality for healthcare access in the wake of COVID-19 and with CMS coverage of telehealth markedly expanding, DRCCC aims to enable more rural patients to utilize telehealth as a potent solution to rural access to care barriers. Current patterns of telehealth availability and usage will be integrated into the Needs Assessment and Gap Analysis, where patient access to telehealth will remain an agenda item for the Steering Committee for the entirety of the project period. CHWs will be able to request and distribute appropriate technology to patients in need, such as tablets.

6. Collaboration with payers to develop alternative payment models (APMs)/pilot payment models: With a view toward long-term sustainability for Delta REACH, DRCCC will prioritize engagement of public and private payers in developing APMs and pilot payment models. As CHW services are not currently reimbursed by Medicaid, this work will not only promote project sustainability, but will also advance advocacy for policy reform that could make the CHW model more attractive and achievable for any health systems serving vulnerable populations. Notably, six CAHs currently participate in an ACO managed by ICAHN. Since its inception in 2015, the ICAHN ACO has achieved significant improvements in the quality metrics reported by participating hospitals and has received and distributed over $3 million in value-based reimbursements. This experience serves as a clear asset to DRCCC's ability to engage payers, develop payment models, and demonstrate measurable outcomes.

Timeframe of the project: With careful consideration of project goals and related activities, DRCCC will lay the groundwork for governance, needs assessment, community engagement, evaluation planning, and technology infrastructure over the majority of Year 1. A phased implementation of the CHW model will begin with 4 hospitals during the last three months of Year 1 and expand to implementation at the remaining 5 hospitals during the first six months of Year 2. The initial 4 CAHs for Year 1 were selected on the basis of their capacity and resources to immediately implement project activities. This gradual rollout ensures a strong foundation for successful achievement of project goals and prevents overwhelm of rural CAHs. An overview of project activities by year follows:

Year 1: DRCCC and 9 Community Advisory Boards (1 for each CAH partner) convened; Project Director hired; Community Needs Assessment and Gap Analysis completed; technology platform developed; 8 CHWs (4 1.0FTE, 4 0.4FTE to ensure coverage on nights and weekends) recruited, hired, and trained; 4 APRNs recruited, hired, and trained; evaluation plan formalized;

CHW model implemented at 4 CAHs (Ferrell Hospital, Franklin Hospital, Memorial Hospital, Sparta Community Hospital *(Focus on Quality Pillars: Adult Behavioral Health and Child Behavioral Health).*

Year 2: 10 additional CHWs recruited, hired, and trained within 3 months (5 1.0FTE, 5 0.4FTE to ensure coverage on nights and weekends); 5 additional APRNs recruited, hired, and trained; CHW model implemented at remaining 5 CAHs within 6 months; evaluation plan implemented within 1 month, with creation of monthly key metrics/progress reports *(Focus on Quality Pillars: Adult Behavioral Health, Child Behavioral Health).*

Year 3: Evaluation ongoing, with creation of monthly key metrics/progress reports *(Focus expanded to Quality Pillars: Adult Behavioral Health, Child Behavioral Health, Equity, and Community Based Supports).*

Year 4: Creation of comprehensive report detailing cumulative data analysis of HFS Pillar Quality Metrics, key project achievements and challenges, to share with key community stakeholders and payers willing to discuss potential pilot payment models within six months; sustainability plan drafted within nine months.

Year 5: Update of comprehensive report detailing cumulative data analysis of HFS Pillar Quality Metrics, key project achievements and challenges, to share with key community stakeholders and payers willing to discuss potential pilot payment models within six months; engagement of HFS, State Medicaid Agency, and other key stakeholders to advocate for expanded reimbursement to include CHWs within six months; sustainability plan finalized within six months.

Alignment of the budget to project goals: DRCCC's budget includes the financial support necessary to achieve each of the project's key strategies. Adequate salary/benefits for all key personnel ensures the recruitment of qualified candidates for the Project Director, CHW, APRN, and Equity Coordinator positions. Concrete interventional supports such as kits (clothing, track phone, meal gift card, etc.) to distribute to patients experiencing homelessness have been factored into our planning. A significant amount of funding is devoted to ensuring a comprehensive, high-quality evaluation, as demonstrating measurable impact is essential to DRCCC's long-term goals for project sustainability and advocacy for policy reform.

Form 3: Governance Structure

Structure and Processes

1. **Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?**

ICAHN, as the lead applicant, will act as the convener and project lead for the Delta Region Care Coordination Collaborative (DRCCC) and the Delta REACH project. ICAHN will provide overall oversight and management of the project, including hiring and housing the Project Director, who will be hired upon award. The Collaborative will include a fiscal agent, Franklin Hospital District, one of the project's Critical Access Hospitals in order to collaborate with ICAHN on financial management and reporting requirements of the project. This includes the disbursement and accounting of all funds and financial and single audit review of the project. The fiscal agent/ICAHN will provide financial reports to the Steering Committee, at least quarterly. The DRCCC Steering Committee will include representation from ICAHN and each of the critical access hospital partners. Key project staff, including the Project Director and the Equity Coordinator, will also participate in the DRCCC Steering Committee as well as a representative from Southern Illinois University's (SIU) project evaluation team. One of the CHWs will attend each DRCCC Steering Committee meeting, where a different CHW will rotate in for each meeting. The CHW will not be a voting member of the Steering Committee, but will attend in order to provide the Steering Committee will information regarding "on the ground" implementation – challenges and successes. The Steering Committee will also include patient representatives from each county to ensure we are engaging those benefiting from the project while gathering ongoing community input.

The Steering Committee will be responsible for high-level decision making around policies and procedures specific to the CHW-implemented activities, relationships/referrals with CBOs/FBOs, and data collection and project evaluation. The Steering Committee will employ policies and procedures informed by Community-Based Participatory Approaches, a methodology considering trusted community members as "gatekeepers" who must share decision-making authority with all other partners in order to ensure the success of an intervention. The Steering Committee will support the needs of the fiscal agent and will review and advise on financial matters as needed.

The Steering Committee will meet weekly during the first month of the project period and will meet monthly thereafter. Pertinent information, data, and other findings will be disseminated to all collaborative members; formal reports detailing project achievements and challenges will be created by the Project Director on a quarterly basis and distributed to all members prior to meetings. Decision making around the day-to-day activities of project implementation will be the responsibility of the Project Director and the community-level APRN/LCSW; high-level project decisions, including direction, policy, or evaluation changes, will be brought to the Steering Committee for input, dialogue, and ultimately, a decision with each representative having an equal vote. Within the Steering Committee, we anticipate having multiple subcommittees to focus on various key elements of the project including: 1) Needs Assessment/Gap Analysis; 2) Alternative Payments; 3) Equity and Diversity; and 4) Evaluation. The CAH partners, all of who will participate in the Steering Committee, have signed an MOU outlining their responsibilities

to the project, which has been included with this proposal. An organizational chart is also included to provide a visual representation of the governing structure of the collaborative.

In addition to the Steering Committee, each critical access hospital will create a Community Advisory Board that will include representation from community stakeholders/partners, such as community-based organizations, faith-based organizations, mental/behavioral health treatment providers, and social determinants of health services (housing, education, economic development, etc.) with a concerted effort to include diverse, meaningful representation from minority groups. The Community Advisory Board will be responsible for convening stakeholders specific to the CAH service area, focusing on how to improve and establish a more formal, culturally competent continuum of care for patients and address social determinants of health. The Community Advisory Board will assign one member to participate in the DRCCC Steering Committee to represent the local community voice at the regional level.

Accountability

2. **How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?**

Ultimately, the DRCCC Steering Committee will hold each collaborating entity and Community Advisory Board accountable for achieving outcomes tied to the Delta REACH project. Information and data on progress toward goals, including project outcome measures, will be shared with each committee member prior to each quarterly meeting, where any issues or challenges identified regarding achieving outcomes will be brought to the attention of the committee. Committee members will provide advisement, support, and resources as needed to improve an entity's capabilities and capacity to meet project goals.

The MOU (signed by each CAH) and the letters of commitment (provided by CBOs and other partners) define the roles and responsibilities of each entity, including any resources, financial or otherwise, committed to the project, which includes language ensuring that each entity will act prudently, ethically, legally, and with extensive participation. If an entity chooses not to adhere to certain policies and/or procedures, the Steering Committee will act to try and remedy the compliance issue. If the issue cannot be remedied or the entity continues not to act in accordance with the required policies and procedures, the entity will be removed as a collaborative partner and will no longer be able to participate in the project.

New Legal Entity

3. **Will a new umbrella legal entity be created as a result of your collaboration?** No
   a. **Provide details on the new entity's Board of Director's, including its racial and ethnic make up:** Not Applicable
   b. **Upload any documentation or visuals you wish to submit in support of your response (combine into a single document for upload)**

4. **How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.**

ICAHN has significant experience managing and administering federal and state grants, along with other funding sources. ICAHN has a well-vetted grant management and contract procurement program for managing state, federal, and private grants. ICAHN has a detailed subcontractor tracking process and can manage large state and federal awards as evidenced by no opinion single audit findings. ICAHN has served as the subcontractor for IDPH Center for Rural Health implementing annually the Medicare Rural Hospital Flexibility (CAH Program) and Small Hospital Improvement Program grants since 2004. Both are federal state office grants requiring ICAHN to have CAH technical expertise and the ability to develop and oversee statewide programs, individual hospital, and community projects, along with possessing grant administrative skills and subcontractor management processes. ICAHN routinely contracts with statewide organizations, universities, and consultants. ICAHN is registered with the System for Award Management (SAM) and the State of Illinois Procurement Office.

In 2014, ICAHN established a statewide rural Accountable Care Organization (ACO) called Illinois Rural Community Care Organization (IRCCO) LLC, where in 2015, it was approved by CMS as a Medicare Care Shared Savings Program (MSSP). IRCCO was approved by Illinois Blue Cross and Blue Shield Shared Savings Program in 2017. Currently, IRCCO has 27 CAHs and small rural hospitals in its ACO and serves 45,000 Medicare beneficiaries and 42,000 BCBS beneficiaries in its savings program. When IRCCO started in 2015, less than one percent of Medicare beneficiaries had an annual well visit. Today, IRCCO averages close to 50 percent of its Medicare beneficiaries who have an annual well visit. This example demonstrates ICAHN's history of and continued capability to create healthcare delivery change across 27 rural systems.

As stated previously, ICAHN will use a fiscal agent – Franklin Hospital, which is a Critical Access Hospital located in Franklin County. Franklin Hospital will collaborate with ICAHN to conduct financial tracking and reporting, including providing direct payments to providers within the collaborative. Franklin Hospital is a Medicaid provider and has the ability to bill services directly to Medicaid, which is why ICAHN has chosen to use a fiscal agent. As the project explores alternative payment options to support the work of the CHWs, it is important to have a Medicaid-eligible biller acting as the fiscal agent. Franklin Hospital also has significant experience managing and reporting to state and federal grant programs including USDA grants; grants provided by ICAHN including DRCHSD, SHIPO, and Flex; as well as grants through SRH, ASPER, and recent grant funding through the CARES Act. This experience is why Franklin Hospital was chosen to be the fiscal agent.

Together, ICAHN and Franklin Hospital are perfectly suited to oversee and manage the payments to providers and CAHs and to ensure funding is used as directed by HFS and the Delta REACH project. Each entity/provider receiving funds will be required to report back to Franklin/ICAHN (at least on a quarterly basis) on how the funds were used to support project implementation. This report will include a financial breakdown of how funds were spent, including provider payments, CHW salary, etc.

Form 4: Racial Equity

High level description of how the design of your proposal incorporates racial equity: Comprised of a largely white population, the IDR has a dark history of racial oppression, segregation, and injustice. This project is a demonstration of the DRCCC's commitment to acknowledging the region's history while advancing a targeted approach to improving racial equity for its Black/African American and Hispanic/Latino residents. DRCCC Governance structures integrates diversity, equity, and inclusion organizations into its Steering Committee; key project personnel includes an Equity Coordinator and an Equity Subject Matter Expert to ensure that attention to racial equity undergirds every strategy. Moreover, the DRCCC selected the CHW model precisely for its ability to engage the target population through a culturally-competent approach.

1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal? Although the majority of the Delta Region is white, Black/African-Americans and Hispanic/Latinos reside in every county in the region. 4.89% of the population across the 12 target counties is Black/African American, 2.49% is Hispanic/Latino, and 1.71% is two or more races.[6] It is critical to note that despite these overall low rates of racial/ethnic diversity, there has been explosive growth in minority population in several of the target counties in recent decades. In Hamilton County and White County, for example, the percentage of white residents decreased by 2.0% and 4.7%, respectively, while the percentage of Black/African American residents increased by 46.6% and 40%, respectively, between 2000 and 2010.

With regard to which groups will be most affected by the project, all Medicaid-eligible individuals across racial/ethnic backgrounds will be affected by project activities. On the other hand, given a history of racial oppression and segregation, it is the Black/African American and Hispanic/Latino populations who may be most concerned with the issues related to this proposal. Whereas the issues of poverty and rurality are endemic to the IDR population at large, the concept of racism being a public health issue is only now coming to the forefront of national dialogue, where its dissemination to rural regions will likely occur more slowly than in urban areas. Nevertheless, the impact that this concept and related initiatives can have on improving the lives of minority populations is sweeping.

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged? Each of the 9 partner CAHs will conduct a CHNA every three years with the goal of performing a data-driven assessment of community health combined with community members' input on key health priorities and needs. Most recent completed CHNAs are from 2018 or 2019, and all incorporate input via focus groups and surveys from racially/ethnically diverse community members. Additionally, ICAHN has a strong history of collaboration with the National Association for the Advancement of Colored People (NAACP) and the Illinois Migrant Council (IMC). Both of these organizations were heavily involved in identifying gaps in care and barriers to accessing care among racial/ethnic minority populations in the region to inform project design. IMC has a long history of successfully leading healthcare programming for migrants, farmworkers, and the Hispanic/Latino population in Illinois. In response to the COVID-19 pandemic, IMC serves as the largest statewide community-based

[6] U.S. Census Bureau. American Community Survey. 2019: 5-year estimates.

partner to IPHA on a COVID-19 Pandemic Health Navigator Grant employing hundreds of culturally competent community health workers in marginalized populations. The NAACP, working with a strong network of African American churches, has led community-based efforts to enroll minority populations into insurance plans through the Affordable Care Act, educated minority communities about chronic disease, and provided health education to minority females on the importance of breast cancer screening. Emphasizing the NAACP's and IMC's ability to represent diverse voices is an enormous stronghold of this project.

Despite this foundation of engagement and representation, there is much work to be done to amplify diverse voices in IDR discussions around improving racial equity in healthcare. As question 4 below explores in further detail, a confluence of factors has pushed the white population of Southern Illinois to a pivotal moment in its ability to understand racism in terms articulated by Women's Studies professor Peggy McIntosh in 1989: not as "individual acts of meanness," but as "invisible systems conferring dominance" on white people.[7] DRCCC aims to seize this moment by implementing a project that – through engagement of diverse stakeholders woven into its governance structure and key activities – creates a conduit for ongoing conversation around the tenets of white privilege undergirding the healthcare system.

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed? Due to the pervasiveness and persistence of structural racism, the white population is most advantaged by the issues this proposal seeks to address. The Black/African American population is most disadvantaged, followed by Hispanics/Latinos. Although all three racial/ethnic groups in the target service area experience higher rates of poverty, lack of educational attainment, unemployment, and poor health outcomes, Black/African Americans and Hispanics/Latinos are more severely impacted by these disparities than their white counterparts. This inequity has been laid bare by the COVID-19 pandemic, which has resulted in death rates among racial/ethnic minorities that far outpace the white population. In Illinois, Black/African Americans represent 10.59% of COVID-19 cases, but account for 18.37% of COVID-19 deaths.[8] New research performed at Oregon State University found that racial and ethnic minorities living in rural areas were at significantly greater risk of death from COVID-19 than those living in urban areas[9]; the co-author of the study concluded that "living in a rural area on top of being a member of a racial minority group acts as a "double whammy."[10] Although the rural poor experience barriers to healthcare across racial/ethnic lines, evidence points to the fact that Black/African Americans experience barriers most acutely, as these individuals grapple with deep-seated, historically-based distrust of the healthcare system.[11] This fear and hesitancy to engage with the medical system, combined with higher incidence of chronic health conditions and more severe barriers to care, result in high numbers of Black/African Americans receiving necessary medical care in the ED.

---

[7] McIntosh, P. (2003). White privilege: Unpacking the invisible knapsack. In S. Plous (Ed.), *Understanding prejudice and discrimination* (pp. 191–196). McGraw-Hill.

[8] Johns Hopkins University. 2021. https://coronavirus.jhu.edu/data/racial-data-transparency

[9] Iyanda, A.E., *et al.* (2021) Racial/Ethnic Heterogeneity and Rural-Urban Disparity of COVID-19 Case Fatality Ratio in the USA: a Negative Binomial and GIS-Based Analysis. *Journal of Racial and Ethnic Health Disparities.* doi.org/10.1007/s40615-021-01006-7.

[10] Ibid.

[11] https://proceedings.med.ucla.edu/wp-content/uploads/2020/06/Wells-A200421LW-rko-Wells-Lindsay-M.D.-BLM-formatted.pdf

Plentiful data exists underscoring racial/ethnic disparities in health status/outcomes, access to care, and social determinants of health in the target service area. One clear exception to this, however, is ED utilization data. As our project focuses on the ED as the access point to services, we examined ED utilization data closely and found significant inequities in data collected for ED visits by condition and race/ethnicity. For example, the Illinois Public Health Community Map provides both "ED Type 2 Diabetes Visit Rate: All Races" and "ED Type 2 Diabetes Visit Rate: White for each of 102 IL counties. However, for "ED Type 2 Diabetes Visit Rate: Black/African American" and "ED Type 2 Diabetes Visit Rate: Hispanic/Latino," no data exists for 7/12 and 9/12 of the counties, respectively.

Additionally, project design reflects the fact that there are currently no standardized processes for collecting or sharing: 1) population health data and outcomes, or 2) care coordination-related data and outcomes between health care organizations and CBOs in the region. A priority of the project, therefore, is to collect data capable of delineating a wide range of racial/ethnic health disparities.

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it? The IDR includes several areas of "sundown towns" where, by official policy, black people were not allowed after dark into at least the 1960s in some cases.[12] Sundown towns exemplify the formal and informal policies that, according to a growing body of research, account for the extremely low representation of racial/ethnic minorities in rural areas. By upholding the "no coloreds after dark" policy, these areas "drove out existing black residents and/or kept others from moving into the town."[13] Decades after these policies were dropped, their legacy underscores the fact that racial/ethnic minorities still face residential segregation, with the white population living in neighborhoods that are nearly all white, and African Americans and Hispanic/Latinos living in neighborhoods with few, if any, white people. This racial residential segregation is often described as the "structural lynchpin" of racial inequality in America:

> "Because so much of what happens to a person is driven by where they live – things like where they go to school, what services they receive, and their access to transportation, medical services and employment opportunities – racial residential segregation is implicated in persistent racial inequalities."[14]

This project, though not able to transform housing/neighborhood infrastructure, will directly address the SDOH influencing health inequity and health disparities for racial/ethnic minorities in the IDR. DRCCC plans to seize the momentum, described in media reports, of a growing determination among IDR residents to acknowledge a history of racial oppression and to address the systemic effects of structural racism following the death of George Floyd and the events of summer 2020. One article described multiple June 2020 protests organized and attended by white individuals in areas of Southern Illinois that were once "sundown towns." For example, a Black Lives Matter protest held in Franklin County was organized by a white man who was born in the

---

[12] James W. Loewen. Sundown Towns: A Hidden Dimension of American Racism (New York: Simon and Schuster, 2005).
[13] Krysan, M. (2009). "Racial Residential Segregation and Exclusion in Illinois." The Illinois Report 2009. University of Illinois: Institute of Government and Public Affairs.
https://igpa.uillinois.edu/sites/igpa.uillinois.edu/files/reports/IR09-Ch4-Segregation.pdf
[14] Ibid.

county in 1994, a year before it served as the site of a large KKK rally.[15] The fact that public opinion can allow for a KKK rally and a BLM protest within a single generation reflects both the challenges and the potential inherent in rural, mostly white counties for social reform. Change may be slow, but it is possible. This project serves as demonstration of the target population's ability to reconcile with its past and change its future.

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination? Delta REACH seeks to pilot a targeted approach for reaching the Medicaid eligible population in 12 rural counties by embedding CHWs in the EDs of rural CAHs. We have intentionally designed the model with the ED as the access point because it is the experience of CAH providers that vulnerable populations, particularly individuals experiencing dire poverty, addiction, mental health issues, and/or those of racial/ethnic minority backgrounds, often wait to seek care until they are in crisis.

DRCCC has elected to implement the CHW model, rather than a nurse navigator or other care coordination position, precisely because of its proven ability to engage diverse and/or disadvantaged populations. Given that the target population's overall numbers of racial/ethnic minority populations are relatively low, DRCCC may not be able to exclusively hire CHWs from minority racial/ethnic populations; nevertheless, all individuals hired into the position will demonstrate a unique connection and familiarity with the target population, along with a willingness to receive training and demonstrate competency in culturally-competent modalities of engagement and interaction. As one analysis of 18 CHW interventions found, the most highly valued attributes of CHWs include "knowledge of host community, communication skills, and personality."[16]

At the systems level, this proposal aims to serve as a clear demonstration of the IDR's willingness, as a largely white region in a nascent stage of reckoning with structural racism, to support actionable efforts toward change. In this way, Delta REACH embeds the recommendation of the AAFP that:

> "organizations take an active approach to dismantling racism by conducting a comprehensive critical examination of policies and procedures, empowering the development of diverse formal and informal leadership at all levels and developing a plan that increases accountability, demonstrates transparency and reorganizes power."[17]

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized? A potential negative consequence would be confusion among CAH staff/providers over the role and purpose of the CHWs. As the CHWs will have Medical Assistant training, staff/providers may attempt to utilize the CHW to provide clinical support in the ER, rather than the intended role as liaison and care coordinator. This will be prevented by educating all CAH ED staff/providers on the purpose of this project and the responsibilities of

---

[15] https://www.nbcchicago.com/news/local/southern-illinois-towns-are-dealing-with-racist-past/2290453/?_osource=db_npd_nbc_wmaq_eml_shr

[16] Hohl SD, Thompson B, Krok-Schoen JL et al. Characterizing community health workers on research teams: results from the Center for Population Health and Health Disparities. *Am J Public Health.* 2016;106(4):664–670.

[17] American Academy of Family Physicians. (July 2019). Institutional Racism in the Healthcare System. https://www.aafp.org/about/policies/all/institutional-racism.html

the CHW. In terms of positive impacts and opportunities for equity, Delta REACH is designed to achieve the following:

- More equitable access to care: By addressing current fragmentation of care and providing a culturally-competent "missing link" through the CHW/APRN Care Teams, Delta REACH will enhance access to care for the Delta's most vulnerable residents, including the uninsured and impoverished, Blacks/African Americans, and Hispanic/Latinos whose marginalization is compounded by poverty and SDOH challenges. Barriers including insurance, transportation, access to care/supply gaps, and scheduling will be directly addressed through the model.
- Focus on racial health disparities: Delta REACH will prioritize key health disparities impacting African American and Hispanic/Latino residents of the Delta Region, including mental health and chronic disease morbidity and mortality, by connecting patients to primary and specialty care and providing the wraparound support necessary to address the SDOH that often impact their ability to receive this care. Given research pointing to lower vaccination rates among minority populations, promoting vaccine confidence and providing vaccine education will be among the CHWs' activities.
- Increased culturally competent providers: Through the CHW/APRN care team model, DRCCC will increase access to a provider workforce that is more culturally responsive and culturally competent. Through the role of the Equity Coordinator, staff and providers of each CAH will receive comprehensive cultural competency training that is strategically integrated into the "education days" scheduled regularly for each entity.

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion? DRCCC considers this project to be a pivotal advancement in the Delta Region's ability to acknowledge structural racism and advance racial equity. As an area that is still largely white, it will take targeted, evidence-based approaches such as this one to drive forward incremental change in the population's awareness of racial disparities and ability to address them. Although it would be ideal for every CAH ED to embed both a CHW of Black/African American background and a CHW of Hispanic/Latino background, project leadership is aware that given the proportionally low numbers of these individuals in the population, it is not pragmatic to set that goal. Lived experience of the county's priority populations will be an essential requirement, and recruitment will also follow the evidence-based guideline that candidates should be primarily evaluated on qualities including empathy and cultural connectedness, rather than academic qualifications.[18]

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability? DRCCC has carefully considered the scope of the project, the resources necessary to support its success, and the timeframe best suited to its execution. Key elements of project design reflect DRCCC partners' nuanced understanding of the needs of the target population; for example, CHWs will be embedded in EDs as they are often the access point to care for vulnerable, Medicaid-eligible individuals. Phased implementation ensures steady focus on project goals, in two different ways:

---

[18] Peretz. P., et. al. (Nov 2020). Community Health Workers and Covid-19 — Addressing Social Determinants of Health in Times of Crisis and Beyond. N Engl J Med 2020; 383:e108 https://www.nejm.org/doi/full/10.1056/NEJMp2022641

1) the CHW model will be implemented in two phases, in 4 CAHs during Year 1, and 5 CAHs during Year 2; and 2) focus will begin with HFS Quality Pillars Adult Behavioral Health and Child Behavioral Health during Years 1-2, while expanding further to include Equity and Community Supports for Years 3-5. Project activities will encompass all four Quality Pillars over five years, but we are aiming to be accountable for quality metrics gradually, thus ensuring that the data collection and evaluative methods prove nimble across a smaller scope before expanding to all four Pillars. With regard to stakeholder participation, DRCCC partners represent organizations that are actively and enthusiastically committed to this project and its transformative potential. The project will rely heavily on community member input through Steering Committee representation, where Community Advisory Boards for the service area of each CAH support the project's ability to remain closely tied to the needs and priorities of local communities. Finally, the hiring of an Equity Coordinator to lead integration of culturally-competency and racial/ethnic equity into every key activity is foundational to DRCCC's ability to deliver on its goal of addressing structural racism and advancing equity.

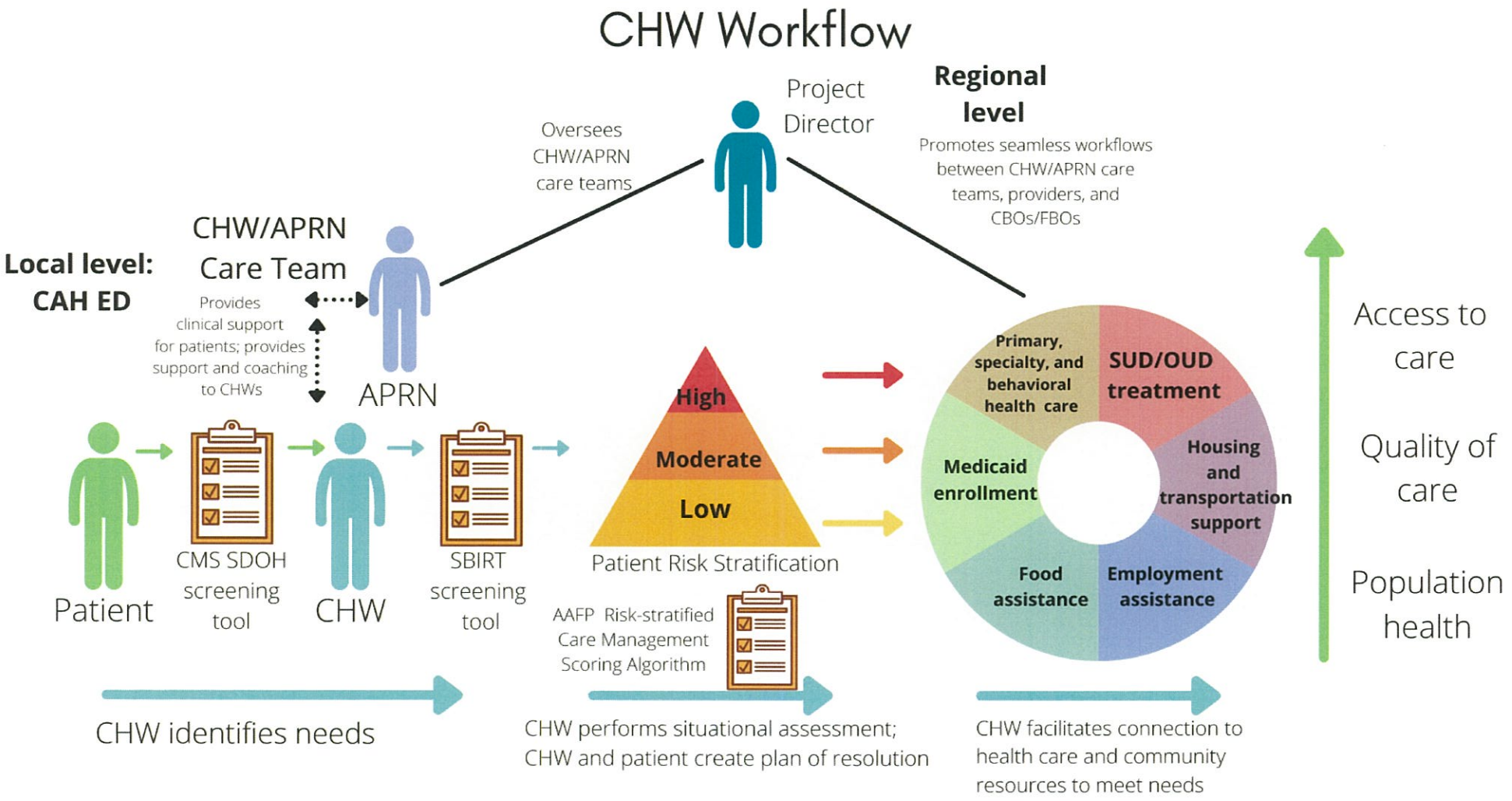
With regard to public reporting and public accountability, Southern Illinois University (SIU) will spearhead a comprehensive evaluation capable of producing clear analysis of project impact, achievements, and challenges. SIU has been selected not only for their history of successful engagement of IDR populations in health research, but also for their public declaration of being an anti-racist university system committed to diversity, equity, and inclusion efforts.[19] The SIU School of Medicine will lead the project's comprehensive Evaluation Plan, which will include both process and outcome indicators for project success. Both the process of redesigning the system of care for rural Illinois residents, and the impacts of this redesign on health outcomes, health equity, and quality of life, will be examined by the thorough Evaluation component of the project. The project evaluation will ensure a comprehensive assessment of the level, diversity, and quality of stakeholder engagement in the project.

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed? As described in **Form 13: Quality Metrics**, DRCCC will track and report data for several metrics across 4/5 Quality Pillars (Adult Behavioral Health and Child Behavioral Health in Years 1-2, adding in Equity and Community Supports in Years 3-5). All data will include a demographic breakdown by median household income, poverty status, and race/ethnicity to fully assess project impact on health equity and racial equity. Success indicators will include a number of patients served whose demographics represent that of the target service area; in other words, for a CAH with a target service area population that is 94% white, 3% Black/African American, and 3% Hispanic/Latino, patients served must include at least a similar breakdown. Another success indicator will be the procurement of ED utilization data by condition and race/ethnicity, which is currently unavailable. Progress benchmarks will include improvements in HFS metrics, such as the percent of 7-day and 30-day follow up after ED visit for Mental Health. Improvement will be measured in relation to baseline data gathered during the Needs Assessment and Gap Analysis or will be compared year-over-year for measures for which baseline data cannot be gathered.

With respect to the assessment of the level, diversity and quality of ongoing stakeholder engagement, detailed records will be kept for attendance at DRCCC Steering Committee and all

[19] https://www.wpsdlocal6.com/news/southern-illinois-university-system-striving-to-become-an-anti-racist-organization/article_7edf7afe-3262-11ec-bd04-774df210e166.html

subcommittees (including the Equity Subcommittee) meetings. Minutes will be recorded and shared across all Committee/Subcommittee members. Community-based participatory approaches will drive each meeting of the Steering Committee and subcommittees, ensuring that diverse voices are invited, heard, and given due authority in project development, execution, and evaluation.


CHW Workflow
Project Director
Regional level
Promotes seamless workflows between CHW/APRN care teams, providers, and CBOs/FBOs
Oversees CHW/APRN care teams
Local level: CAH ED
CHW/APRN Care Team
Provides clinical support for patients; provides support and coaching to CHWs
APRN
Patient
CMS SDOH screening tool
CHW
SBIRT screening tool
High
Moderate
Low
Patient Risk Stratification
AAFP Risk-stratified Care Management Scoring Algorithm
Primary, specialty, and behavioral health care
SUD/OUD treatment
Housing and transportation support
Employment assistance
Food assistance
Medicaid enrollment
Access to care
Quality of care
Population health
CHW identifies needs
CHW performs situational assessment; CHW and patient create plan of resolution
CHW facilitates connection to health care and community resources to meet needs

Form 5: Community Input

Service Area of the Proposed Intervention

1. **Identify your service area in general terms (e.g., West Chicago, East St. Louise Metro Area, Southeastern Illinois):**

Southern Illinois Delta Region

2. **Please select all Illinois Counties that are in your service area:**

Edwards, Franklin, Hamilton, Jackson, Lawrence, Massac, Perry, Pope, Randolph, Saline, Wabash, White

3. **Please list all zip codes in your service area:**

62217, 62233, 62237, 62238, 62241, 62242, 62257, 62259, 62261, 62272, 62274, 62277, 62278, 62280, 62286, 62288, 62292, 62297, 62410, 62417, 62439, 62460, 62466, 62476, 62806, 62812, 62820, 62821, 62822, 62827, 62828, 62832, 62833, 62834, 62835, 62844, 62852, 62859, 62860, 62861, 62863, 62865, 62867, 62869, 62884, 62888, 62890, 62897, 62901, 92902, 62903, 62905, 62906, 62907, 62908, 62909, 62910, 62912, 62914, 62916, 62919, 62920, 62922, 62923, 62924, 62926, 62927, 62931, 62932, 62938, 62939, 62940, 62941, 62942, 62943, 62947, 62950, 62952, 62953, 62956, 62957, 62958, 62960, 62961, 62962, 62963, 62964, 62966, 62967, 62969, 62970, 62972, 62973, 62975, 62976, 62982, 62985, 62988, 62990, 62992, 62993, 62994, 62995, 62996, 62997, 62998, 62999, 63748, 63770, 63775, 63673, 63783

Community Input

1. **Describe the process you have followed to seek input from your community and what community needs it highlighted.** The Southern Illinois Delta Region has a strong record of cooperation focused on community, healthcare, and economic initiatives. Specifically, counties within the Delta Region have come together to form well-structured and strategically driven organizations such as the Healthy Southern Illinois Delta Network (HSIDN) and the SI Now economic development initiative. Through these existing channels as well as through local hospital's Community Health Needs Assessments (CHNAs) and health department's Illinois Project for Local Assessment of Needs (I-PLANs), comprehensive community input related to health needs, economic needs, and overall social determinants have been complied. Due to the Delta's strong sources of community input, dire, healthcare and economic needs, and well-functioning collaboration networks, DRCC members identified the region as an ideal pilot location.

Throughout the past few months, ICAHN and its CAH partners have reviewed community data and information in order to determine the most prevalent needs in the Delta Region. Each CAH partner entity has its own processes and tools for seeking community input. Collectively, this input has informed the project scope and activities. A summary of each entity's current community input process is outlined below:

Marshall Browning Hospital:

- The Community Champion and hospital executive team held virtual events with community groups to review health outcomes and understand community members' and partners' priorities. Three groups evolved from those meetings and include Mental Health, Good Jobs & Healthy Economy, and Healthy Behaviors & Lifestyles. The three groups are currently working together to help meet the community's health needs identified.
- Marshall Browning Hospital meets every four months with a Community Advisory Committee that is a diverse group of members of the community. Its mission is to identify and serve the healthcare needs of the community and the surrounding area.
- Marshall Browning Hospital is currently working with an additional community member focus group and health care focus group to determine the community health care needs. Results will be reported on the Community Health Needs Assessment for approval in 2022.
- Conducted a Community Health Survey
- Conducted Marshall Browning Hospital Questionnaire

Franklin Hospital District

- Through meetings for the Delta Region Community Health Systems Development (DRCHSD) Grant Project, we have been able to identify community needs.

Massac Memorial Hospital

- Community Health Needs Assessment (most recent – 2019)

Memorial Hospital

- Community Health Needs Assessment and focus groups (2019)
- Patient Family Advisory Council – meets quarterly

Sparta Community Hospital District

- Community Liaison conduct focus groups on mental health and food disparities
- Patient surveys
- Patient Family Advisory Council
- Mobile Clinic Services out in the community

Ferrell Hospital

- Community Health Needs Assessment

Wabash General Hospital District

- Community Health Needs Assessment (2021)

Hamilton Memorial Hospital District

- Community Health Needs Assessment (2015)

- CQIC project focusing on patient and family engagement includes meetings with community and family members to gather input

Pinckneyville Community Hospital

- Have Community Coordinator focusing on engaging the target population and gathering input on healthcare needs and priorities

Additionally, the CBOs that have been engaged as sub participants of the Delta REACH project (ComWell, Centerstone), along with two equity/diversity-focused entities (Illinois Migrant Council and Carbondale NAACP) gather information on community needs from their specific constituents, including BIPOC, low-income, and rural residents. The information they've gathered in recent years has been used to inform the Delta REACH project design and ensure the project has a strong emphasis on equity and inclusion.

DRCCC members, however, do see a need to improve and expand upon how they will garner community input throughout the 5-year project, especially focused on underserved populations. In addition to utilizing the CHNAs and other already existing activities noted above, DRCCC will engage the community on its healthcare transformation efforts via routine qualitative focus groups across the Delta Region to better understand how project efforts are being received, any potential gaps needing to be addressed, and challenges in its implementation in order to continuously improve the project to make a difference in the lives of the residents living in the communities served.

The initial needs assessment/gap analysis conducted in the first year of the Delta REACH project will also expand the way in which the DRCCC gathers community input to inform the development and implementation of the project. Additionally, hiring an Equity Coordinator and collaborating with entities such as the Carbondale NAACP and the Illinois Migrant Council will allow the DRCCC to identify and define ways to engage underserved and underrepresented populations, thus ensuring the input received from the community is representative of all populations benefiting from the project.

<u>Input from Elected Officials</u>

1. **Did your collaborative consult elected officials as you developed your proposal?**
    a. **If you consulted IL federal or state legislators, please select all legislators whom you consulted:**
    Senator Dale Fowler – 59th District
    Dave Severin – State Representative 117th District

    b. **If you consulted local officials, please list their names and titles:**
    Randolph County Board of Commissioners – Dr. Marc L. Kiehna, Chairman
    Rocky D. James – Mayor of Eldorado
    Robert L. Spencer – Mayor of Pinckneyville

Form 6: Data Support

1. Describe the data used to design your proposal and the methodology of collection.

Delta REACH's design is based on a data-driven analysis of community need as well as extensive community input. It is important to note that the Delta Region is the only region in the state for which there is no existing UIC Community Needs Report. Additionally, as mentioned previously in **Form 4. Racial Equity**, there are significant inequities in data collection and dissemination between racial/ethnic representation in key metrics, including ED utilization rates. Despite these gaps, DRCCC is confident that the project design reflects community data from a wide range of sources and responds to some of the most pressing health and SDOH needs in the target population. Sources include qualitative/quantitative input from NAACP and IMC, Community Health Needs Assessments, American Community Survey, the Centers for Disease Control and Prevention WONDER, CMS Chronic Conditions by County, Illinois Department of Public Health IQuery, and County Health Rankings and Roadmaps.

DRCCC's projected number of patients served over five years of funding was developed through careful analysis of each CAH patient census for a 12-month period in 2020-2021, including calculation of the percentage of Medicaid patients. Project design was directly informed by the experience of CAHs—uniform across all 9—that overutilization of EDs is heavily driven by Medicaid patients. This experience is supported in the literature on the national level; according to a 2019 National Center for Health Statistics report, adults under the age of 65 with Medicaid were approximately twice as likely to report having gone to the ED in the past year compared to those who are privately insured. Income and poverty is also closely correlated to ED utilization; nationally, patients located in communities with the lowest median income have the highest rates of ED visits, and the rate falls as incomes go up.[20]

Social Determinants of Health: As noted by Healthy People 2030, social determinants of health (SDOH) are "the conditions in the environments where people are born, live, learn, work, play, worship, and age affecting a wide range of health, functioning, and quality-of-life outcomes and risks." **Table 1** details some of the most prescient socioeconomic experienced by the target population. In seven of 12 target counties, the median household income is 25% lower than the state average; in Jackson County and Pope County, median household income is a full 40% lower than the state. Children are disproportionately affected by poverty, and the disparities in poverty between white and African American populations are sobering. In two counties, African Americans live in poverty at a rate that is more than five times greater than that of their white neighbors.

Table 1. Socioeconomic/poverty indicators

	Population without health insurance	Median household income	People living in poverty	Children living in poverty	% Caucasian living in poverty	% African American living in poverty	% Two or more races living in poverty	% Hispanic/ Latino living in poverty
Edwards	6.2	51,080	10.2	11.4	9.9	33.3	23.3	25.8
Franklin	6.3	42,769	19.5	25.2	19.0	33.5	28.5	41.7

[20] https://aspe.hhs.gov/sites/default/files/private/pdf/265086/ED-report-to-Congress.pdf

Hamilton	5.4	54,046	9.3	8.5	9.2	61.5	n/a	0.0
Jackson	6.4	37,241	26.5	29.2	20.4	49.6	40.2	38.3
Lawrence	7.6	46,636	16.2	24.4	15.6	14.3	7.2	38.7
Massac	5.4	47,481	16.7	20.2	16.0	24.8	22.4	51.9
Perry	3.9	52,428	16.1	24.2	15.9	31.7	20.1	29.9
Pope	4.0	38,056	15.3	17.4	15.9	14.3	n/a	15.4
Randolph	5.2	53,816	12.7	19.5	12.0	17.7	22.2	34.9
Saline	4.2	44,090	21.1	29.2	20.5	30.4	35.9	9.2
Wabash	7.1	50,770	12.0	11.9	12.5	6.3	0.4	0.3
White	4.8	49,290	14.0	19.5	13.7	69.6	28.2	25.0
Illinois	6.8	65,886	12.5	17.1	9.4	26.1	16.0	16.1
United States	8.8	62,843	13.4	18.5	11.1	23.0	16.7	19.6

Source: U.S. Census Bureau, American Community Survey. 2019: 5 year estimates

IDR residents experience food insecurity and limited access to healthy foods at higher rates than across the state and nation, as shown in **Table 2**. Children, again, bear a disproportionate burden of food insecurity, with 11 of 12 counties having a percentage of children eligible for free or reduced lunch that is higher than the state; in Jackson County and Massac County, nearly three quarters of children are eligible. Although housing issues are less prevalent than across the state, IDR residents struggle with unemployment to a greater degree than the state and nation as a whole. Lack of access to broadband internet is a significant problem, with all 12 counties having lower rates of access than the state and nation.

Table 2. Socioeconomic and Physical Environment Indicators

	Food Insecurity	**Limited Access to Healthy Foods**	**Children Eligible for Free or Reduced Lunch**	**Unemployment**	**Severe Housing Problems**	**Broadband Access**
Edwards	10%	8%	38%	4.1%	7%	78%
Franklin	15%	4%	55%	5.4%	13%	73%
Hamilton	10%	4%	52%	3.9%	8%	73%
Jackson	15%	11%	71%	3.8%	20%	78%
Lawrence	14%	5%	56%	5.2%	9%	75%
Massac	15%	4%	67%	5.6%	16%	67%
Perry	13%	10%	49%	5.1%	13%	75%
Pope	14%	8%	61%	5.6%	8%	61%
Randolph	11%	3%	49%	3.7%	8%	77%
Saline	16%	20%	59%	5.3%	13%	72%
Wabash	11%	2%	53%	3.8%	10%	77%
White	12%	14%	55%	3.8%	10%	75%
Illinois	10%	4%	49%	4.0%	17%	83%
Top U.S. Performers	9%	2%	32%	2.6%	9%	86%

Source: County Health Rankings and Roadmaps, 2021

Health disparities and health needs

Disease burden: As **Table 3** shows, the target population bears a disproportionate rate of death from heart disease, stroke, and COPD, as well as prevalence of chronic disease and conditions such as diabetes and hypertension. Nine of 12 counties have heart disease death rates higher than that of the state and nation. Jackson is the only County that has data available by race/ethnicity for heart disease death rate; there, the heart disease rate is 257.1 among Blacks/African Americans compared to 165.4 county-wide. Chronic Lower Respiratory Disease (CLRD) death rates are higher across all 12 counties; residents of Franklin, Hamilton, and Saline Counties are more than twice as likely to die of CLRD than residents across Illinois and the U.S.

Table 3. Death rates and disease prevalence

	Heart Disease death rate	Stroke death rate	CLRD death rate	Diabetes prevalence	Obesity prevalence	Chronic Conditions among Medicare beneficiaries	
						Hypertension	Hyperlipidemia
Edwards	296.4	66.1	44.6	9.0%	30%	60.7%	37.9%
Franklin	165.6	41.5	84.9	12.5%	33%	62.2%	44.8%
Hamilton	183.7	48.4	79.6	12.0%	29%	57.3%	31.7%
Jackson	165.4	31.8	37.7	7.8%	25%	59.0%	41.9%
Lawrence	192.0	38.3	51.6	13.9%	30%	63.7%	37.6%
Massac	105.6	39.0	75.5	11.7%	35%	67.9%	52.4%
Perry	198.9	37.3	50.1	10.1%	28%	60.7%	31.6%
Pope	139.7	n/a	n/a	11.7%	26%	60.6%	39.6%
Randolph	180.8	52.5	56.2	8.2%	38%	64.6%	46.7%
Saline	228.8	42.4	80.9	14.7%	27%	59.3%	43.7%
Wabash	122.0	32.5	62.4	12.0%	28%	64.2%	28.8%
White	192.8	38.2	72.5	14.7%	29%	62.6%	41.6%
Illinois	163.1	37.9	38.5	10.2%	30%	58.1%	39.8%
United States	161.5	37.1	41.1		26%	57.1%	40.7%

Sources: Illinois State Department of Health (2019 death rates; diabetes prevalence 2018); County Health Rankings & Roadmaps 2021 (obesity prevalence); CMS County Level Chronic Conditions 2017

Behavioral risk factors: The described disease burden is related to the prevalence of behavioral risk factors in the target population. Significantly more IDR residents smoke and are physically inactive compared to those at the state and national levels. The teen birth rate is staggeringly high in the region, with teens in four counties more than twice as likely to give birth than the state and nation as a whole.

Table 4. Behavioral risk factors

	Smoking	Excessive Drinking	Physical Inactivity	Teen births
Edwards	15%	20%	27%	33

Franklin	18%	19%	29%	46
Hamilton	16%	19%	28%	27
Jackson	19%	19%	25%	20
Lawrence	18%	21%	26%	44
Massac	16%	18%	31%	37
Perry	16%	21%	26%	32
Pope	15%	19%	23%	29
Randolph	17%	20%	27%	32
Saline	19%	18%	36%	47
Wabash	16%	20%	22%	32
White	16%	19%	21%	48
Illinois	15%	21%	22%	21
United States	14%	13%	20%	13

Source: County Health Rankings & Roadmaps, 2021

Mental and behavioral health needs: A severe lack of mental health providers, lack of care coordination in rural health care, and lack of adoption of innovative approaches in mental health care has led to what The Atlantic Monthly dubbed, "The Hidden Crisis in Rural America" in December 2019.[21] The crisis revolves around the fact that although prevalence of mental health issues is consistent among rural and urban populations, mental health outcomes are highly divergent, with rural areas having significantly worse outcomes than their urban counterparts. Rural Southern Illinois reflects this in the available data (for many counties, suicide and drug overdose death rate data is considered unreliable because of small population size). Available data points to higher rates of suicide and drug overdose deaths than the state and nation. The opioid dispensing rate is shockingly high in Jackson County (106.3) and Saline County (127.1), more than twice that of Illinois.

Table 5. Mental and behavioral health risk factors

	Suicide death rate	Drug Overdose death rate	Alcohol-impaired driving deaths	Opioid Dispensing rate	Depression among Medicare beneficiaries
Edwards	n/a	n/a	0%	46.1	10.6%
Franklin	16.0	26	26%	38.4	20.2%
Hamilton	n/a	n/a	40%	9.3	15.5%
Jackson	12.0	20	23%	106.3	20.6%
Lawrence	n/a	n/a	38%	45.8	13.8%
Massac	n/a	n/a	37%	74.3	18.9%

[21] The Hidden Crisis in Rural America. (6 Dec 2019). *The Atlantic Monthly*. https://www.theatlantic.com/video/index/603127/mental-health-rural/

Perry	n/a	19.0	39%	60.9	16.9%
Pope	n/a	n/a	50%	27.5	17.0%
Randolph	n/a	11.0	29%	42.0	19.8%
Saline	31.0	n/a	21%	127.1	18.7%
Wabash	n/a	n/a	33%	33.1	13.4%
White	n/a	n/a	7%	29.4	18.7%
Illinois	10.0	22	31%	43.1	16.3%
United States	13.2	11	11%	46.7	17.9%

Sources: County Health Rankings & Roadmaps 2021 (drug overdose); CDC U.S. Opioid Dispensing Rate Maps 2019; CMS County Level Chronic Conditions 2017

What is particularly alarming about the data presented here is the fact that it was gathered prior to the COVID-19 pandemic. In the 19 months since COVID-19 began spreading through the U.S., Americans have reported significant negative impacts on their mental health. According to a CDC report that surveyed adults across the U.S. in June of 2020, 31% of respondents reported symptoms of anxiety or depression, 13% reported having started or increased substance use, 26% reported stress-related symptoms, and 11% reported having serious thoughts of suicide in the past 30 days; these figures are nearly double what they were in 2019.

Methodology of Data Collection: As part of their spring 2021 HTC application, ICAHN along with multiple partners conducted a thorough review of the majority of the data sources listed above. For this project, given the focus on the ED as the entry point into the CHW model of care, ICAHN examined ED utilization rates more closely. ICAHN also engaged the leadership of its 9 CAH partners through several methods, including one-on-one conversations, group meetings, and the distribution of a "partner survey" that comprehensively assessed each partner's strengths and resources relevant to this project and gathered qualitative (input on characteristics of frequent utilizer patients in the ED; description of the impact of COVID-19 on local health and SDOH needs; current processes for addressing SDOH) and quantitative (number of total Medicaid patients; number of total Medicaid patients among ED encounters; number of providers of diverse racial/ethnic backgrounds) data.

Form 7: Health Equity and Outcomes

1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

As described in **Form 6: Data Support**, the target population faces a host of healthcare disparities, with rurality and poverty driving disparities among the white population, and Black/African Americans and Hispanic/Latino populations demonstrating disparities to a more severe degree than their white counterparts. This project will focus on the following disparities:

Behavioral Health, Mental Health, SUD/OUD: The prevalence of behavioral health and mental health issues, as well as SUD/OUD, is higher in the IDR as compared to the state and nation. According to 2018 data, the IDR has the lowest overall rate of behavioral wellness (as measured by number of mentally unhealthy days reported in the last 30 days) of any region in Illinois.[22] This prevalence, combined with an overall lack of qualified behavioral and mental health providers and SUD/OUD treatment, contributes to high numbers of patients experiencing behavioral health, mental health, and SUD-OUD-related problems or crises landing in the ED. Of these, a significant percentage have Medicaid, in keeping with research showing that adults under the age of 65 with Medicaid were approximately twice as likely to report having gone to the ED in the past year compared to those who are privately insured. Although there is a lack of county-level data on behavioral health/mental health ED utilization by payer mix, nationally, the percentage of ED visits for behavioral/mental health and SUD/OUD with Medicaid as the primary expected payer has increased significantly between 2009-2018, whereas the percentage of ED visits for non-behavioral/mental health with Medicaid as the primary expected payer has decreased.[23] This suggests a strong correlation between poverty and behavioral/mental health issues and SUD/OUD, and furthermore evidences a lack of available care beyond the ED. Additionally, a recent report issued by the United Nations points to sharp increases in behavioral/mental health issues among children as a result of the COVID-19 pandemic, with poor and vulnerable children hit particularly hard.[24] Given the disproportionate numbers of children in poverty across the IDR as compared to the state and nation, it is likely that CAH EDs will see ED utilization rates by Medicaid patients increase.

With regard to racial/ethnic disparities, although there is a lack of county-level data for ED Utilization for Behavioral Health broken down by race/ethnicity, state-level data has found that the Black/African American population's ED Utilization for mental health is nearly twice that of the white population.[25] This disparity sadly extended to children even before the pandemic, with mental health-related ED visits highest among Black/African American children, and rates among Hispanics increasing at a significantly higher rate when compared with whites.[26] Through the CHW model, this project will address causes encompassing lack of appropriate medical care and behavioral health supports as well as SDOH (lack of stable housing, food insecurity, lack of transportation). This model reflects best practices recommended by SAMHSA

---

[22] Illinois Public Health Community Map, Behavioral Wellness, 2018. Retrieved from http://www.healthcarereportcard.illinois.gov/maps

[23] Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2019-2018.

[24] https://apnews.com/article/coronavirus-pandemic-business-france-mental-health-pandemics-0d12fba9ec9408ca6325ecd39b914733

[25] http://www.healthcarereportcard.illinois.gov/files/pdf/ED_Report_2015.pdf

[26] Abrams, Anna, et.al. (2020 Sep 3). Racial and Ethnic Disparities in Pediatric Mental Health-Related Emergency Department Visits. Pediatr Emerg Care. https://pubmed.ncbi.nlm.nih.gov/32898125/#article-details

in its "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit," namely the recommendation to "link individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises," such as primary care, therapy, family support services, and inpatient treatment.[27] DRCCC has chosen to address these causes on the basis of input from key stakeholders pointing to the fact that in every CAH ED, "frequent flyers," or individuals who come to the ED multiple times per month, have behavioral/mental health and/or SUD/OUD that cannot be successfully treated in the long run without addressing root causes. Many of these individuals do not have a primary care provider, let alone a behavioral health provider, and face daily impediments to recovery through lack of housing, attaining necessary medications, or proper nutrition.

Chronic Disease Morbidity and Mortality: As highlighted in **Form 6: Data Support**, the target population experiences overall higher rates of chronic disease as compared to the state and nation. As with patients presenting with behavioral/mental health and/or SUD/OUD issues, IDR residents with chronic disease often land in the ED because they a) lack an ongoing, stable source of primary/behavioral health care and b) struggle with myriad SDOH exacerbating their health issues. DRCCC CAH partners uniformly report that approximately 50% of ED visits are for conditions that can be treated by primary care providers. Causes of this situation include a lack of patient education and awareness around the availability of care; barriers to accessing care including lack of insurance; and SDOH impacting ability to fully realize the benefits of care, such as lack of housing stability and food insecurity. For racial/ethnic minorities, these causes are further compounded by longstanding marginalization and structural racism. DRCCC has chosen to address these causes firstly because of its confidence that doing so will increase access to care and improve health outcomes for the most vulnerable among the target population, and secondly because several of the participating CAHs have developed chronic care management programs over the last six years and have seen measurable improvements in quality of care metrics and cost-savings-per-patient. This is representative of the fact that although services, resources, and programs exist in the service area, there is currently a lack of standardized connection between these resources and the patients who most need them.

Moreover, DRCCC is choosing to address these causes out of an awareness that the long-term effects of COVID-19 on the physical health of a target population already struggling with disproportionately high rates of chronic disease may be grim. 2021 studies have pointed to potential life-threatening conditions lingering or developing even after a patient has recovered from COVID-19. A study of competitive college athletes who tested positive for COVID-19, but who did not experience any symptoms, found evidence of heart inflammation through MRIs, prompting researchers to postulate "increased incidence of heart failure as a major sequela of COVID-19 with considerable potential implications for the general population of older adults with multi-morbidity."[28] Another study of 57 recovered COVID-19 patients found that half still struggled with respiratory muscle weakness and difficulty breathing; "if compounded on cardiovascular comorbidity, either preexisting or incident from COVID-19, persistent decline in lung function could have major adverse cardiopulmonary consequences."[29] Between patients with pre-existing chronic health conditions that are gravely worsened by COVID-19 and patients

---

[27] SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[28] del Rio C, Collins LF, Malani P. Long-term Health Consequences of COVID-19. *JAMA.* 2020;324(17):1723–1724. doi:10.1001/jama.2020.19719

[29] Ibid.

experiencing "long COVID," vulnerable rural populations will likely present with increased rates of chronic conditions.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting? This project's key activities will address these disparities and harness measurable impacts in the following ways:

Implementation of the CHW model: CHWs will serve as the "missing link" between available health care and community resources and patients presenting in the ED who can most benefit from them. CHWs will be capable of walking patients through a suite of holistic services and supports that can not only improve their health, but their quality of life. Most importantly, CHWs will do this work in culturally competent ways and will be able to form relationships of trust with vulnerable, diverse populations. The model ensures proper clinical supervision and support by embedding APRNs who will ensure appropriate medical, psychiatric, and psychological supports for each patient's plan of resolution. Impacts will be immediate and encompass a range of improvements, from patient empanelment with a PCP, patient enrollment in Medicaid, patient registration for subsidized housing, and patient registration with a community transportation support system.

Development of the technology platform: The technology platform animating a standardized structure for care coordination and follow-up will allow CHWs to provide interventions and make referrals in a systematic way and to track patients' successful engagement with these interventions. Currently, there is no standardized system for CAHs to monitor what happens to patients after they leave the ED, and no way to track whether patients showed up to their referral for primary care, behavioral health services, or psychiatric services. The impact of this technology is immediate and far-reaching; the ability to search by patient name and evaluate what progress or challenges they are experiencing with regard to their plan of resolution empowers the CHW to immediately address gaps in care.

Creation of a regional approach to improving health equity: Hiring an Equity Coordinator to lead the development and execution of a unified health equity strategy is key to DRCCC's ability to improve health equity. By organizing key stakeholders at the regional (NAACP, IMC) and local (CBOs representing/serving diverse populations) levels on the Equity Subcommittee and by delivering comprehensive cultural competency training to providers and staff of 9 CAHs, the Equity Coordinator will directly increase the number of culturally competent providers in the region and will drive forward the ability of the DRCCC to provide care meeting the unique needs of historically marginalized populations in the IDR.

3. Why will the activities you propose lead to the impact you intend to have?

A large body of research supports the efficacy of CHWs on positively impacting health outcomes among vulnerable populations, including the rural poor as well as racial/ethnic minorities. A review of 67 studies examining the impact of CHWs on chronic disease management and care among people at risk for health disparities (defined as economically disadvantaged, the uninsured, racial and ethnic minorities whose health problems "often intersect with social factors such as housing, poverty, absence of a usual source of care, and inadequate education") found that:

> "compared with no intervention or other alternatives, partnering with CHWs tended to result in increasing screening tests for breast, cervical, and colorectal cancers; decreasing blood pressure, blood glucose, and weight; and promotion of exercise in study samples. In several studies reporting costs, CHWs tended to save costs as well. Our findings support the benefits of working with CHWs in promoting health among people who are at risk for health disparities."[30]

Although less measurable, the CHW model leverages relationships of trust and respect between the patient and the health care system. CHWs are distinguished from other medical staff and providers in that they have a unique ability to relate to and engage with the target population. This capacity for compassion, according to SAMHSA, is critical to improving care: "perhaps the most potent element of all, in an effective crisis service system, is relationships. To be human. To be compassionate. We know from experience that immediate access to help, hope and healing saves lives."[31]

With regard to cultural competency training, a multitude of studies have found that cultural competency training results in positive outcomes for improved practitioner knowledge, skills, and attitudes/beliefs. However, there is a lack of definitive evidence that cultural competency training directly improves health outcomes. Nevertheless, given the fact that there has never been a targeted regional approach to cultural competency in health care in the region. DRCCC believes that improving the knowledge, awareness, and ability of providers and staff to effectively engage the rural and impoverished population, as well as racial/ethnic minority populations, will address the somewhat invisible web of interconnected barriers preventing the achievement of true health equity.

---

[30] Kim K, Choi JS, Choi E et al. Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: a systematic review. Am J Public Health. 2016;106(4):e3–e28.

[31] SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Form 8: Access to Care

1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes. Compared to urban areas, residents of rural areas experience a greater need for health services combined with a more limited capacity to meet those needs.[32] The Delta Region experiences a grievous lack of qualified health providers, as demonstrated by the target counties holding HSPA and/or MUA designation.

Table 6: HPSA/MUA Designations

County	HPSA Primary Care by Designation Type	HPSA Mental Health by Designation Type	MUA (Entire County)
Edwards	Geographic	Geographic	X
Franklin	Low Income Population	Geographic	X
Hamilton	Geographic	Geographic	
Jackson	Low Income Population	Geographic	X
Lawrence	Low Income Population	Geographic	X
Massac	Low Income Population	Geographic	X
Perry	Low Income Population	Geographic	
Pope	Geographic	Geographic	X
Randolph	Low Income Population	Geographic	
Saline	Low Income Population	Geographic	
Wabash	Geographic	Geographic	X
White	Low Income Population	Geographic	X

Despite this overall lack of qualified health providers, each of the 9 participating CAHs offer primary care and varying degrees of specialty care (some CAHs with a wide range of in-house specialists; others referring patients to specialists across the region). Similarly, the availability of behavioral health care and SUD/OUD treatment is highly variable across the region. Although this project's Needs Assessment and Gap Analysis will execute a formal, systematic inventory of available care and supports, **Table 7** provides an overview of the services available through each CAH:

Table 7: Available Care through 9 CAHs

CAH	Primary Care	Specialists	Chronic Care Management Program	BHS (in-house)	BHS (through referral)	SUD/OUD Treatment Program (through referral)
Ferrell	X	X		X (geriatric psych outpatient program; LCSW in one of the CAH's rural health clinics)	X	X (referral and in-house FNPs with buprenorphine waivers)

[32] Lenardson, J., & Gale, J. A. (2007). Distribution of substance abuse treatment facilities across the rural urban continuum. (Working Paper #35). Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center.
https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1033&context=behavioral_health

Franklin	X	X		X (LCSW in one of the CAH's rural health clinics hired with a start date in 12/2021)	X	X
Hamilton Memorial	X	X		X (LCSW in one of the CAH's rural health clinics)	X	X
Marshall Browning	X	X	X		X	X
Memorial	X	X	X	X (LCSW)	X	X
Massac Memorial	X	X		X (psychiatrist at one of the CAH's rural health clinics)	X	X
Pinckneyville Community	X	X	X			
Sparta Community	X	X	X		X	X
Wabash General	X	X	X	X		X

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting? Beyond the current supply gaps and fragmentation of services, the target population encounters multiple barriers to accessing care, including poverty, lack of insurance, lack of transportation, and lack of broadband internet access. For racial/ethnic minorities, marginalization in largely white communities and deep-seated distrust of the healthcare system only exacerbates existing barriers. Delta REACH will undertake the following activities and achieve associated impacts:

- Addressing Supply Gaps: Through initial analysis of available primary, specialty, behavioral health, and SUD/OUD care in each of the target counties, delineated in Table 7, DRCCC has ascertained that a range of providers serves each community. The current breakdown in the chain of care is ensuring that eligible patients are aware of these services and receive referrals, where they actually complete the referral by attending the appointment. Delta REACH's CHW model and development of a technology platform will directly addresses this issue, thus establishing a culturally-competent safety net infrastructure for Medicaid-eligible patients seen in the ED. This infrastructure does more than direct patients to services; it utilizes a standardized system for follow-up, preventing "frequent flyers" in the ED by providing them with ongoing assistance in navigating their care.
- Addressing Insurance Barriers: All 9 CAH partners report treating patients in the ED who are eligible for Medicaid but are not enrolled. One of the key functions of the CHW will be enrollment of eligible patients in Medicaid. For patients who are not eligible, but still experience financial barriers to care, the CHW will refer to the closest CAH-affiliated rural health clinic, so that the patient may pay for care on a sliding fee scale. These activities will immediately impact patients' ability to receive necessary care.

- Addressing physical barriers: In some of the region's most rural areas, such as Franklin County, vulnerable populations often completely lack the transportation necessary to travel 40-60 miles to a specialty physician. In these cases, the CHW/APRN Care Teams will utilize telehealth to ensure patient access to necessary care. Other counties have existing provisions for transportation barriers, such as RIDES, a public mass transit system serving Southern Illinois offering discounts for persons with disabilities and individuals over 60 years of age. The CHW will include transportation support in the plan of resolution for any patients in need. These activities will immediately and directly address transportation barriers, which are ubiquitous in rural regions like IDR.
- Addressing lack of a uniform telehealth strategy: The availability of telehealth services across the 9 CAHs is currently highly variable, with no regional strategic planning efforts underway. Recognizing that telehealth is likely to continue to expand as a viable method of health care and that CMS regulations and requirements may change to reflect this, DRCCC plans to devote significant time to considering strategies for scaling telehealth across the 9 CAHs.

3. Why will the activities you propose lead to the impact you intend to have? Access to care in the IDR is heavily impacted by fragmentation of care. Although subsets of the 9 CAHs participating in the project have previously collaborated on other initiatives, Delta REACH represents the first coordinated effort to increase access to care, improve quality of care, and advance equity in twelve of the 16 IDR counties. By creating a solid infrastructure for referrals between the health system and community-based resources and supports, and fortifying that infrastructure with the technology capable of animating and evaluating it, DRCCC positions its key stakeholders to have lasting, measurable, and replicable impacts on access to care.

Form 9: Social Determinants of Health

1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes. According to the World Health Organization, "research shows that the social determinants can be more important than health care or lifestyle choices in influencing health."[33] Disparities in social determinants of health are experienced acutely in the target population, and reflect the fact that "rural America experiences many inequities compared to the nation as a whole. Often rural residents have fewer individual resources and, on average, are poorer and less educated."[34] These inequities cannot be explained by the obvious impact of geographic isolation from the same range of services and opportunities available in urban areas. Rather, rural disparities ranging from economic mobility to health outcomes "reveal a relationship between health, opportunity, and place that runs much deeper than the issue of geographic isolation."[35]

DRCCC partners agree addressing SDOH is essential to increasing access to care, improving health outcomes, and advancing equity. As discussed in Form 6: Data Support, the target population faces SDOH that are salient drivers of barriers to care and poor health outcomes including:

- High rates of poverty
- Lack of health insurance
- Lack of educational attainment
- High rates of unemployment
- Racial segregation
- Food insecurity and inaccessibility of nutritious food choices
- Low access to housing and utility services
- Adverse childhood experiences (ACEs)
- Availability of transportation
- Lack of broadband internet access

[33] World Health Organization. (nd). Retrieved from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
[34] https://www.ruralhealthinfo.org/topics/social-determinants-of-health
[35] National Advisory Committee on Rural Health and Human Services Policy Brief. (January 2017). https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-social-determinants.pdf

The relationship between SDOH and health emerges clearly from available county-level data. Saline County, for example, has the second lowest median household income, the second highest percentage of people living in poverty, the highest percentage of children eligible to receive free or reduced lunch, and the highest rate of food insecurity across 12 target counties. These SDOH profoundly impact health outcomes. Saline County has a suicide death rate that is nearly three times as high as the state's rate; the second highest rates of heart disease deaths and CLRD deaths across 12 counties; and the highest opioid dispensing rate across 12 counties.

DRCCC seeks to address the causes of these SDOH from an understanding that little progress can be made with regard to healthcare access and health outcomes when these factors are not taken into consideration. For example, leadership from each of the CAHs describe "frequent flyers" of EDs as exemplifying the fact that there is a lack of wraparound, holistic care for vulnerable patients. These patients are treated in the ED and return, again and again, because they need expanded care incorporating strategies for addressing their environment and experiences, not just their health conditions.

The need to address SDOH is more critical now than ever, as many experts wager that the COVID-19 pandemic and its effects are far from over. Rural populations struggling to make ends meet prior to the pandemic continue to experience enormous stress that is likely to impact long-term physical and mental health, where "the exacerbation of social determinants of health will last for years (and likely decades), which will have long-term implications for mental health."[36] A study published in January 2021 examined how rural populations are faring during the pandemic, asking respondents to rate the impact of COVID-19 on their overall life as well as on their mental health, household finances, and physical health. 53% of respondents stated that COVID-19 had most negatively impacted their overall life. The next largest negative impact, however, was to mental health with 43.7% reporting some level of negative impact.[37] Given that mental health care in rural America was in crisis prior to the pandemic, it is hard to underestimate the stress that rural populations and the health systems serving them may experience in coming years.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

- Governance structure designed to emphasize the critical role of CBOs: Through the work of the Project Director, the DRCCC Steering Committee will interface regularly with Community Advisory Boards (one for each CAH's target service area), comprised of a representative from each participating CBO and attended by the Project Director and the CHW embedded in that area's CAH ED. The primary goal of the Community Advisory Boards will be to provide input on progress and challenges they experience in receiving patient referrals from the CHWs and meeting patient needs. The impact of this governance structure will be to immediately create a channel for communication between a large group of CBO stakeholders, the CHW/APRN Care Team, and the DRCCC Steering Committee.
- Equity Coordinator to lead engagement of diverse voices, ensure project's penetration

[36] Smalley, K., and Warren, J. (2 Dec 2020). The Long Term Impact of COVID-19 on Mental Health. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2020/long-term-impact-covid-19-mental-health

[37] J. Tom Mueller, et.al. Impacts of the COVID-19 pandemic on rural America. Proceedings of the National Academy of Sciences Jan 2021, 118 (1) 2019378118; DOI: 10.1073/pnas.2019378118

among vulnerable populations, and deliver culturally-competent education: Establishing a full-time position devoted to integrating diversity, inclusion, and equity across project scope is a clear demonstration of DRCCC's commitment to addressing root causes through Delta REACH. The Equity Coordinator will be tasked with ensuring that every project activity is implemented with a view toward the long-term goal of advancing health equity. The involvement of Linda Flowers, Carbondale NAACP Executive Director, as the Equity Subject Matter Expert, as well as the role of Diversity, Equity, and Inclusion Organizations (e.g., NAACP, IMC) further support the project's ability to address the complex relationship between SDOH, racism, and health inequity.

- Project Director to coordinate addressing SDOH across the region: Given a 12-county target service area, the need for a position coordinating the workflows and referral patterns between CHW/APRN Care Teams, healthcare providers, and CBOs is critical. The Project Director will ensure seamless coordination processes aimed at achieving the greatest possible impact on SDOH.
- CHW model capable of holistically meeting the health and SDOH needs of each individual: The CHW model is anchored in the ability to address SDOH, as CHWs come from the communities they serve and have a unique understanding of the informal and formal networks of resources undergirding local communities. Each CAH has forged relationships with a range of CBOs providing services and resources to address SDOH; these relationships are demonstrated via attached letters of commitment from key CBO partners. Connecting patients to these services and offering them ongoing support in navigating what can be an overwhelming matrix of supports and programs will have the immediate impact of addressing the needs directly influencing an individual's health status and outcomes.

Moreover, the following activities support our ability to address SDOH:

- Utilization of a standardized, evidence-based screening tool incorporating SDOH
- Utilization of a standardized, evidence-based risk stratification tool incorporating SDOH
- Utilizing a "situation assessment" and "plan of resolution" to structure interventions incorporating SDOH alongside clinical services
- Developing technology to support care coordination across the health system and community
- Developing an integrated strategy to expand patient access to telehealth services

3. Why will the activities you propose lead to the impact you intend to have? At a macro level, project activities are anchored in a number of evidence-based recommendations for addressing social determinants of health in rural populations. A January 2017 National Advisory Committee on Rural Health and Human Services policy brief titled "Social Determinants of Health" examined key elements affecting the capacity of rural areas to impact SDOH, such as lack of resources and a strong emphasis on local autonomy. The brief offers policy recommendations for effectively addressing SDOH in rural communities including:

a) utilization of pilot payment models for reimbursement of clinical services;
b) breaking down funding silos through blended resources; and
c) taking a community integrated approach to aligning resources for population-centered, population health-focused strategies, with "leadership from a 'backbone organization'

and set of cross sector stakeholders such as hospitals, social service providers, employers, businesses, and the education sector."[38]

Delta REACH reflects each of these recommendations. The DRCCC aims to: 1) create alternative payment models for CHW reimbursement; 2) apply for grant funding to benefit all stakeholders; and 3) take a true community integrated approach by coalescing multiple stakeholders (including CAHs and CBOs) into a collaborative that will leverage the resources of each to advance a common goal, with ICAHN providing leadership as a "backbone organization."

At a micro level, project activities are designed to impact the target population's quality of life, from short-term assistance, such as arranging an Uber to get them home from the ED, to long-term interventions, such as helping them access broadband internet in order to have telehealth appointments with a cardiologist. Governance by diverse stakeholders will ensure that design and delivery of services is adequate and appropriate. Engagement through the CHW/APRN care teams will ensure that every individual's plan of resolution encompasses not only health care, but the myriad SDOH determining how they access and receive it.

[38] National Advisory Committee on Rural Health and Human Services Policy Brief. (January 2017). https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-social-determinants.pdf

Form 10: Care Integration and Coordination

1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care. As care coordination and care management continue to be under-funded in Medicaid reimbursement rates, this project will provide a demonstrable improvement in the ability to not only integrate and coordinate care, but to track data on key indicators. During initial discussions for this project, all DRCCC partners cited fragmentation of care as a critical barrier to meeting the needs of their target populations. Although the target service area has multiple provider types and levels of care, there is a severe lack of coordination between them. For example, some CAHs have their own behavioral health providers. If a patient is seen in the CAH ED and referred to a behavioral health provider, there is currently no mechanism by which the ED provider would be able to see if this was a closed loop referral. Specifically, DRCCC partners acknowledged the following as contributing factors to the fragmentation of care:

- Variability between EHR systems of different providers and different levels of care, resulting in a lack of communication and technology to support closed loop referrals for specialty care or social services;
- Lack of any uniform, formalized mechanism through which providers can share information on patient health; and
- Lack of any formalized system for tracking patient referrals to health system or community-based supports.

A systematic investigation of these gaps in care and infrastructure will be achieved through the completion of the Needs Assessment and Gap Analysis. As no such regional assessment currently exists, this project activity significantly boosts the DRCCC's ability to directly address areas of greatest need. Furthermore, Delta REACH directly addresses fragmentation of care through the implementation of the CHW model and through the development of a technology platform to address care integration and coordination.

2. Do you plan to hire community health workers or care coordinators as part of your intervention?
X Yes
No

2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable). DRCCC expects that each CHW/APRN Care Team (9; one Team embedded in each of 9 CAH EDs) will provide initial screening through the CMS SDOH screening tool to approximately 100 Medicaid-eligible individuals per month. However, only a portion of the total patients served will require ongoing case management by the CHWs. Utilizing recommendations from best practice guides, such as the Center for Healthcare Strategies brief, "Integrating Community Health Workers into Complex Care Teams," DRCCC estimates a caseload of 40-60 patients per month for each CHW.[39] An analysis of available existing data from DRCCC CAHs suggests that risk stratification will result in the following breakdown: 15% high risk; 35% moderate risk; 50% low risk.

[39] https://www.chcs.org/media/CHW-Brief-5-10-17.pdf

COST PER CASELOAD: Total projected patients served, i.e., patients who are screened by CHW/APRN Care Teams through the CMS SDOH screening tool, over Years 1-5 is 44,400. However, as described, only a portion of these patients will require long-term, ongoing case management by the CHW/APRN Care Teams; we estimate that each Care Team will manage a caseload of 40-60 patients per month. This translates to a cost per caseload as follows:

In Year 1, 4 CAHs will implement the CHW model for months 10-12 of Year 1. This translates to 4 CHW/APRN Care Teams, each serving 40-60 patients per month, over a three-month period. Therefore, each of the 4 Care Teams will serve a total caseload of 120-180 patients during Year 1. The Year 1 Budget of $1,579,391 divided by a 120-180 patient caseload = cost per caseload of $13,161.59-$8,774.39.

In Year 2, 9 CAHs will implement the CHW model for all 12 months of Year 1. This translates to 9 CHW/APRN Care Teams, each serving 40-60 patients per month, over a 12-month period. Therefore, each of the 9 Care Teams will serve a total caseload of 480-720 patients during Year 2. The Year 2 Budget of $3,510,751 divided by a 480-720 patient caseload = cost per caseload of $7,314.11-$4,876.04

In Year 3, 9 CAHs will implement the CHW model for all 12 months of Year 1. This translates to 9 CHW/APRN Care Teams, each serving 40-60 patients per month, over a 12-month period. Therefore, each of the 9 Care Teams will serve a total caseload of 480-720 patients during Year 3. The Year 3 Budget of $3,528,680 divided by a 480-720 patient caseload = cost per caseload of $7,351.42-$4,900.94.

In Year 4, 9 CAHs will implement the CHW model for all 12 months of Year 1. This translates to 9 CHW/APRN Care Teams, each serving 40-60 patients per month, over a 12-month period. Therefore, each of the 9 Care Teams will serve a total caseload of 480-720 patients during Year 4. The Year 4 Budget of $3,617,965 divided by a 480-720 patient caseload = cost per caseload of $7,537.43-$5,024.95.

In Year 5, 9 CAHs will implement the CHW model for all 12 months of Year 1. This translates to 9 CHW/APRN Care Teams, each serving 40-60 patients per month, over a 12-month period. Therefore, each of the 9 Care Teams will serve a total caseload of 480-720 patients during Year 5. The Year 5 Budget of $3,709,928 divided by a 480-720 patient caseload = cost per caseload of $7,729.02-$5,152.68.

3. Are there any managed care organizations in your collaborative?
Yes
X No

3A. Please list the names of the managed care organizations in your collaborative.

3A. If no, do you plan to integrate and work with managed care organizations?
X Yes
No

3B. Please describe your collaborative's plans to work with managed care organizations.
In concert with its engagement of the State Medicaid agency to develop APMs and advocate for policy reform, DRCCC will disseminate project results to MCOs with a market share in the IDR. DRCCC will engage MCOs and pursue the development of pilot payment models that could drive forward the case for CHW reimbursement for private pay patients.

Form 11: Minority Participation

1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the IL BEP and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

Carbondale NAACP
Illinois Migrant Council

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.

The Carbondale NAACP and Illinois Migrant Council will participate in the Delta REACH project by conducting community outreach across the region, specifically with BIPOC communities. They will provide volunteers and outreach efforts as vital resources to support the project. The Carbondale NAACP and Illinois Migrant Council will be involved during project implementation by participating on the Steering Committee, including supporting the efforts of the Equity & Diversity subcommittee and working closely with the Equity Coordinator to ensure culturally competent care and support across the nine CAHs. It is anticipated that these two entities will also have an ongoing role after the 5-year project period, continuing to be engaged in care transformation across the Delta Region.

Both the Carbondale NAACP and Illinois Migrant Council have experience engaging BIPOC populations in healthcare related needs. The Carbondale NAACP currently has three pandemic health navigators on staff, implement a diabetes mobile unit, and provides volunteers at community food distribution sites. They also distribute census, PPE and COVID-related information materials in many communities across the region. The Illinois Migrant Council has been the leading force in bringing health information to the population it serves, where it has recently focused on COVID vaccine pop up clinics. Both organizations are seen as a trusted source of information and education and will be a valuable partner to the DRCCC.

Form 12: Jobs

1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

Below is a breakdown of existing employees by job category and a list of zip codes of the employees' residence for each Provider (Critical Access Hospital) partner.

Marshall Browning Hospital Association

Number of employees by job category:
Accountant – 2; Administrative Assistant/Secretary/Receptionist – 8; Admit Person – 11; Aide – 2; Athletic Trainer – 1; Centralized Scheduler – 1; CEO – 1; Certified Respiratory Therapy Tech – 4; Chief Nursing Officer – 2; Chief Operating Officer - 1; Clerk – 23; CNA – 19; Coder – 5; Cook – 6; Dept. Supervisor – 2; Dietician – 1; Director – 9; Driver – 1; ED Intake Coordinator – 2; Environmental Services Tech – 10; Financial Officer – 1; HR Director – 1; Information Technologist – 2; Kitchen Help – 2; Laundry Maid – 1; LPN – 12; Maintenance – 5; Manager – 10; Marketing Director – 1; Med Tech – 4; Medical Assistant – 4; MLT – 8; Nurse Practitioner – 5; Occupational Therapist – 1; Occupational Therapist Assistant – 2; OR Tech – 1; Pharmacist – 3; Pharmacy Tech – 5; Phlebotomist – 7; Physical Therapist – 2; Physician – 3; Physician Assistant – 3; Plant Operations Director – 1; PT Assistant – 9; Radiology Tech – 11; Registered Nurse – 46; Respiratory Therapist – 7; Speech Pathologist – 1; Transcriptionist – 1; Ultrasound Tech – 2; Wellness Screener – 11.

Zip Codes of Employees Residence:
62025, 62237, 62263, 62271, 62274, 62286, 62297, 62383, 62439, 62801, 62812, 62816, 62822, 62832, 62836, 62846, 62864, 62865, 62881, 62884, 62888, 62890, 62891, 62896, 62898, 62901, 62902, 62907, 62915, 62916, 62918, 62924, 62927, 62932, 62933, 62948, 62949, 62951, 62958, 62959, 62966, 62994, 62997, 63301

Massac Memorial Hospital

Number of Employees by job category:
Account Representative – 1; Administrative Assistant – 1; Audiologist – 1; Cardiac Rehab Assistant – 1; Cardiac Rehab Coordinator – 1; Cardio Pulmonary Manager – 1; Care Coordinator – 1; CEO – 1; Certified Coder – 1; Chief Operations Officer – 1; Clinic Access Rep – 5; Clinic Access Supervisor – 1; Clinic Medical Assistant – 3; Clinical Supervisor – 1; CNA – 3; Coder -1; Controller – 1; Cook – 4; COTA – 1; CT Tech – 2; Custodian – 1; Dietary Assistant – 5; Dietary Manager – 1; Dietitian – 2; CFO – 1; Director of Support Services – 1; CNO – 1; EMS Manager – 1; EMT – 20; Environmental Services Manager – 1; ER Manager – 1; Executive Assistant – 1; Floor Tech – 2' HIM Manager – 1; Housekeeper – 10; HR Director – 1; Imaging Manager – 1; Information Services Analyst – 2; Information Technology Manager – 1; Inpatient Manager – 1; Lab Manager – 1; Maintenance Tech – 4; LPN – 16; Mammography Tech – 1; Medical Transcriptionist – 1; Clinic Manager – 1; Maintenance Manager – 1; Revenue Cycle Manager – 1; MLT – 10; MRI Tech – 2; MT – 1; New Beginning Manager – 1;

Nurse Intern – 3; Nurse Practitioner – 4; Occupational Therapist – 1; Office Assistant – 1; Pharmacist – 3; Pharmacy Manager – 1; Pharmacy Tech – 2; Philanthropy and Marketing Manager – 1; Phlebotomist – 4; Physical Therapist – 1; Physical Therapy Assistant – 4; Physician – 4; Physician Assistant – 1; PRG Support Specialist – 1; PT Access Clerk – 7; PT Access Manager – 1; Purchasing Manager – 1; Purchasing Clerk – 1; Quality Improvement Manager – 1; Radiology Tech – 2; Records Assistant – 1; Rehab Manager – 1; Respiratory Care Practitioner – 5; Respiratory Test Tech – 3; RN Case Manager – 2; RN – 44; RN Infection Control Coordinator – 1; Scheduler – 2; Sleep Lab Tech – 1 Staff Accountant – 1; Surgery Manager – 1; Surgical Tech – 3; Symptom Monitor – 1; Vascular Tech – 2.

Zip Codes of Employees Residence:
42001, 42003, 42021, 42023, 42024, 42025, 42029, 42044, 42047, 42051, 42053, 42055, 42056, 42058, 42064, 42066, 42069, 42085, 42086, 62901, 62908, 62910, 62912, 62920, 62922, 62923, 62926, 62928, 62930, 62938, 62939 62941, 62943, 62953, 62956, 62959, 62960, 62967, 62985, 62992, 62995, 62996, 62998

Franklin Hospital District

Number of Employees by job category:
Accountant – 1; Accounting Clerk – 1; ACO Coordinator – 1; ACO RN – 1; Administrative Assistant – 1; Advanced Practice Provider Per Diem – 1; Biller – 9; BLS Instructor – 1; Business Office Director – 1; Chief Executive Officer – 1; Chief Nursing Officer -1; Chief Financial Officer -1; Clinical Director – 1; Clinic Manager – 1; CNA – 4; Courier -2; Credentialing Specialist -1; Dietary Aide – 5; Dietary Director – 1; Director of Finance -1; Director of Information Technology – 1; Emergency Room Director – 1; Health Information Director – 1; House Supervisor – 2; Housekeeping Director -1; Housekeeping Technician – 6; Human Resources Director -1; Human Resources Clerk – 1; Lab/Med Tech – 5; Laboratory Director – 1; LPN – 12; Maintenance Director – 1; Maintenance Tech – 4; Material Management Director – 1; Materials Management Clerk – 1; Med/Surge Supervisor – 1; Medical Records Clerk – 2; Medical Records Coder – 3; Medical Scribe – 2; Med/Surge Director – 1; Nurse Practitioner – 4; OR Technician – 2; Patient Financial Services Supervisor – 1; Patient Intake Clerk – 21; Patient Intake Supervisor – 1; PC Specialist – 2; Pharmacist – 6; Pharmacy Director -1; Pharmacy Technician – 2; Phlebotomist – 5; Physician – 5; Physician Assistant – 2; Radiology director – 1; Radiology Tech – 10; RN – 22; RT Supervisor – 1; RT Technician – 3; Senior Care Director – 1; Unit Clerk – 1; Utilization/Case Management Director – 1.

Zip Codes of Employees Residence:
42025, 62231, 62249, 62812, 62816, 62819, 62822, 62823, 62828, 62832, 62836, 62849, 62856, 62859, 62860, 62864, 62865, 62874, 62881, 62883, 62884, 62890, 62891, 62895, 62896, 62897, 62902, 62917, 62918, 62921, 62924, 62930, 62932, 62939, 62946, 62948, 62951, 62959, 62977, 62995, 62999, 63021, 63109

Memorial Hospital

Number of Employees by job category:

Accountant – 1; Accounts Payable – 1; Admin Assistant – 3; Admitting Representative – 5; Admitting Supervisor – 1; Business Office Supervisor – 1; Care Coordinator Manager – 1; CNA – 13; CEO – 1; CFO – 1; Chief Nursing Officer – 1; Chief Radiologic Technician – 1; Clinical Assistant – 2; Coder – 6; Cook – 5; Dietary Clerk – 1; Dietitian – 1; Directors – 13; Discharge Planner & Swing Bed Coordinator – 1; ER Manager – 1; Executive Assistant -1; Floor Technician – 2; Food preparer/tray pass – 2; HIM Associate – 4; Housekeeping – 10; HR payroll/Education Specialist – 1; Infection Control Nurse – 1; Insurance Specialist – 3; IT Tech – 2; Lead Care Coordinator – 1; Lead HIM Associate – 1; Lead Lab Assistant – 1; Linen Clerk – 1; LPN – 20; Maintenance Tech – 3; Marketing – 1; Medical Assistant – 4; Medical Laboratory Technician – 6; Medical Tech – 4; Med Surg Nurse Manager – 1; Nurse Practitioner – 1; OR Tech – 2; OR Manager -1; Patient Account Specialist – 3; Payroll and Reporting Manager – 1; Pharmacist – 3; Pharmacy Tech – 2; Phlebotomist – 4; Physician Assistant – 2; Physician – 5; Project Foreman – 1; Purchasing Clerk – 1; Radiology Tech – 10; Receptionist – 5; Respiratory Therapist – 2; RHC Certified Medical Assistant – 1; RHC Lab Lead – 1; RHC Medical Records Clerk – 2; RHC Nurse Manager – 1; RHC Patient Coordinator – 1; RN House Supervisor – 7; RN – 32; Scanning Specialist – 1; Sleep Technician – 2; Specialized Engineer Craftsman – 2; Specialty Clinic Secretary – 1; Specialty Clinic Supervisor – 1; Storeroom Manager – 1; Third Party Biller – 4; Transcriptionist – 1; Ultrasound Tech – 1

Zip Codes of Employees Residence:

62233, 62236, 622238, 62241, 62242, 62257, 62272, 62274, 62277, 62278, 62280, 62286, 62288, 62292, 62297, 62832, 62907, 62916, 62950, 62966, 62997, 63601, 63670, 63673, 63701, 63748, 63769, 63775

Sparta Community Hospital District

Number of Employees by job category:

Accounting Assistant – 2; AR Cash Receipts – 1; Business Office Manager – 1; Call Center Lead – 1; Call Center Supervisor – 1; Cardiac Rehab Super – 1; Cardiopulmonary/Respiratory Manager – 1; Case Manager – 1; Centralized Scheduler – 8; CEO – 1; CFO – 1; Chief Nurse Executive – 1; Clerical Assistant – 21; Clerical Manager – 1; Clinic RN – 4; Clinic Scribe – 1; Clinic Supervisor – 1; Clinical Assistant – 26; CNA – 16; Coding Manager – 1; Coding Tech – 8; Compliance/Risk Management Associate – 1; Controller – 1; COTA – 1; Courier – 1; Customer Service Rep – 12; Customer Service Supervisor – 1; Diagnostic Image Manager – 1; Dietary Assistant – 6; Dietary Lead – 1; Dietary Supervisor – 1; Director – 9; ED & MS Nurse Manager – 1; ES Tech – 5; ES Tech Lead – 1; Executive Assistant – 1; Fitness Aide – 4; Fitness Supervisor – 1; Health Info Clerk – 5; HIS Supervisor – 1; HIT Tech – 1; Home Health Supervisor – 1; House Supervisor – 4; Information Systems Specialist – 2; Insurance A/R Specialist – 7; Intake Assistant – 3; IT Technical Director 1; Lab Tech – 9; Lab Assistant – 3; Lab Manager – 1; LPN – 3; Materials Buyer – 1; Materials Management Supervisor – 1; MM Stock Clerk – 1; Nurse Practitioner – 12; Occupational Therapist – 2; Occupational Health Coordinator – 1; OR Nurse Manager – 1; OR Tech – 2; Patient Financial Services – 2; Payment Poster – 2; Physical Therapist – 4; Physician – 10;

Physician Assistant – 3; Plant Operations Tech – 4; Plant Operations Manager – 1; PTA – 10; Radiology Tech – 11; RD/Dietary Manager – 1; Referral Coordinator – 1; RN – 45; Rehab Service Manager – 1; Supervisor – 7; Systems Admin – 1; Transaction Entry Specialist – 3; Wellness Nurse – 1.

Zip Codes of Employees Residence:
62214, 62215, 62217, 62225, 62233, 62237, 62238, 62241, 62242, 62243, 62255, 62257, 62258, 62263, 62264, 62265, 62268, 62272, 62274, 62278, 62282, 62285, 62286, 62288, 62292, 62295, 62297, 62298, 62832, 62859, 62888, 62901, 62907, 62966, 62997, 63104, 63116, 63379, 63670, 63775

Ferrell Hospital

Number of employees by job category:
Accountant – 1; Administrative Assistant – 1; AP Specialist/Purchasing – 1; Benefits Coordinator – 1; Biller – 5; Business Office Director – 1; Cardiology Director – 1; Care Coordination Director – 1; Case Manager – 1; CCO/HR Director – 1; Certified Mammography Tech – 2; Certified Medical Assistant – 4; Chief Nursing Officer – 1; Clinic Informatics Specialist – 1; LPN – 22; Clinic Practice Manager – 5; Clinic RN – 7; Director of Nursing – 1; CNA – 9; Coder – 3; Controller – 1; Counselor – 3; Courier – 1; CS Distribution Tech – 1; CT Tech – 1; Dietary Aide – 7; Dietary Supervisor – 1; Director of Mat. Mgmt./IT – 1; Emergency Department Tech – 4; Executive Assistant – 1; Financial Counselor – 2; Hospital Educator – 1; House Supervisor – 4; Housekeeper – 16; Housekeeping Supervisor – 1; Infection Prevention/EE Health – 1; IS Specialist – 1; Lab Assistant – 8; Lab Director – 1; Lead Lab Tech – 1; Maintenance Worker – 5; Med Lab Tech – 7; Medical Tech – 1; Medical Office Rep – 1; Mental Health Tech – 2; Nurse Practitioner – 13; or Director – 1; OR Technician – 2; Pharmacist – 1; Pharmacy Tech – 1; Physician – 6; PI Director – 1; Plant Operations Director – 1; Precertification Clerk – 1; RN – 41; Radiology Director – 1; Radiology Tech – 6; Referrals – 1; Registered Dietitian – 1; Respiratory Therapist – 4; ROI Clerk – 3; Sitter – 5; Service Access Representative – 27; Surgeon – 1; Triage – 1; Ultrasound Tech – 5; Ward Clerk – 3.

Zip Codes of Employees Residence:
42347, 42459, 42460, 46122, 47631, 62810, 62817, 62821, 62827, 62828, 62835, 62837, 62859, 62861, 62863, 62864, 62869, 62871, 62887, 62890, 62896, 62917, 62918, 62919, 62922, 62930, 62931, 62934, 62935, 62938, 62946, 62947, 62948, 62954, 62959, 62965, 62966, 62974, 62977, 62979, 62984, 62987

Marshall Browning Hospital Association

Number of employees by job category:
5 Accounting, 10 Administration, 23 Ambulance, 1 Anesthesia Tech, 6 Athletic Trainer, 1 Cardiac Rehab, 4 Certified Medical Assistant, 8 Coder, 4 CRNA, 9 Environmental Services, 9 ER Tech, 2 FQHC, 3 Human Resource, 4 Information Technology, 22 Laboratory, 5 LPN, 3 Marketing, 6 Materials Management, 5 Medical Records Clerical, 7 Nurse Practitioner, 12 Nursing Assistant, 9 Nutritional Services, 3 Occupational Therapist, 3 Occupational Therapy Assistant, 2 Outreach , 16 Patient Access, 3 Pharmacist, 2 Pharmacy Tech, 5 Physical Therapist, 7 Physical Therapy Assistant, 42

Physician Office Clerical, 10 Physician, 8 Physician Assistant, 5 Plant Operations, 21 Radiology, 1 Referral Coordinator, 2 Registered Dietician, 1 Registrar, 5 Rehab Aide, 9 Respiratory Therapy, 113 RN, 4 Sleep Study, 1 Social Worker, 4 Speech Therapist, 1 Strength And Conditioning Specialist, 8 Surgery Tech, 12 Transcriptionist, 2 Unit Secretary

Zip Codes of Employees Residence:
62863, 62844, 62806, 62476, 62466, 62460, 62454, 62452, 62451, 62450, 62439, 62434, 62427, 62421, 62419, 62417, 62410, 47725, 47720, 47716, 47715, 47712, 47711, 47670, 47665, 47660, 47648, 47639, 47633, 47631, 47630, 47591, 47542, 18222, 22015, 28405, 30102, 30260, 30582, 31602, 32421, 32541, 62864, ,62869 ,62895 62899, 62930, 62932, 62934, 62935, 62979, 63123, 63141, 63645, 64803, 65203, 67205, 67633, 75650, 75707, 77373, 78413, 79789, 79935

Hamilton Memorial Hospital District

Number of employees by job category:
Admin/Medical Staff Services Coordinator – 1; CEO – 1; Chief Nursing Officer – 1; Nursing Administration Secretary – 1; Hospitalist – 2; Med/Surge Level One Tech – 9; Med/Surg LPN – 6; Med/Surg Nurse Manager – 5; Med/Surge RN – 19; ED Level one Tech – 2; ED RN – 6; Infection Prevention/UR Case Management ED Manager – 1; OR Environmental Care Tech – 2; Surgery RN – 2; Surgery Supervisor – 1; Respiratory and Safety Director – 1; Respiratory Care Practitioner 1; COTA -5; Occupational Therapist – 2; Physical Therapist – 3; Physical Therapist Assistant – 7; Rehabilitation Director – 1; Rehabilitation Office Coordinator – 1; Speech Therapist – 1; Radiologic Technologist – 6; Radiology Director – 1; Ultrasound Tech – 1; Cardiac Rehab Nurse – 1; Exercise Physiologist – 1; Laboratory Director – 1; Medical Lab Scientist – 1; Medical Lab Tech – 7; Medical Tech – 1; Phlebotomist – 1; Physician Office Lab Tech – 1; Pharmacy Director/Pharmacist – 1; Pharmacy Tech – 1; CCMA Hospital Clinic – 3; Clinical Director – 1; Clinic Office Manager – 1; LPN– 5; Nurse Practitioner – 6; Physician – 3; Therapist (primary and secondary) – 2; SEC Program Director – 1; SEC RN – 3; Unit Clerk – 1; Environmental Tech – 6; Maintenance Mechanic – 2; Support Services/Life Safety Manager – 1; Clinic Coordinator – 1; Clinic Receptionist – 2; Marketing Manager – 1; Director of Education – 1; Coder – 4; Health Information director – 1; Transcriptionist – 1; Quality/Compliance/Risk Management Director – 1; HR Associate – 1; HR Manager – 1; Health Informatics/IT Manager – 1; IT Help Desk – 1; Billing – 2; Cash Posting Clerk – 2; Collections/Follow Up Coordinator – 1; Medicare Claims and Cost Report Coordinator – 1; Patient Account Rep – 2; Patient Account Rep Coordinator – 1; Revenue Cycle Analyst – 1; Revenue Cycle Manager – 1; CFO – 1; Accountant – 1; Purchasing Director -1; Storeroom Clerk – 1.

Zip Codes of Employees Residence:
47601, 47720, 62589, 62801, 62810, 62812, 62817, 62819, 62821, 62827, 62828, 62835, 62837, 62859, 62860, 62862, 62864, 62867, 62869, 62871, 62884, 62890, 62895, 62896, 62930, 62931, 62934, 62935, 62946, 62948, 62974, 62979

Pinckneyville Community Hospital

Number of employees by job category:

Accountant – 1; Acct./Payroll Clerk – 1; Admin Office Coordinator – 1; Administrative Assistant – 1; ADMINISTRATOR/CEO – 1; BILLING CLERK – 7; Care Coord. Asst. – 2; Care Coord. Clerk – 1; Case Manager RN – 1; CNA – 23; CFO – 1; Chief Nurse Executive – 1; COO – 1; Clinical Care Coordinator – 1; Clinical Doc Specialist – 1; Clinical Manager RN – 1; Coder – 4; Control Tech – 1; COTA – 2; Data Entry Clerk – 1; Department Secretary – 3; Dietary Aide/Cook – 11; Dietary Manager – 1; Dietary Tech – 1; Director of Quality and Risk Management – 1; Education Coordinator RN – 1; ER Manager RN – 1; Fitness Aide – 3; Fitness Coordinator – 1; Ground Maintenance Worker – 1; Health Information Manager – 1; Housekeeper – 14; Housekeeping Manager -1; Huan Resources Director – 2; HVAC Tech – 2; Imaging Manager – 1; Imaging Tech – 11; Information Systems Tech – 1; IT Manager – 1; Lab Manager – 1; Lab Tech – 8; LPN – 15; Maintenance Manager – 1; Maintenance Tech 2; Marketing Director – 1; Materials Manager – 1; Medical Assistant – 1; Medical Record Clerk – 4; Medical Staff Secretary – 1; Nurse Manager – 1; Nurse Practitioners – 9; Occupational Therapist – 1; Office Manager – 2; Oncology Manager (RN) – 1; Pharmacist – 3; Pharmacy Manager – 1; Pharmacy Tech – 3; Phlebotomist – 6; Physical Therapist – 4; Physician – 4; Physician Assistant – 3; Posting/Registration – 1; Pre-certifications/Referrals – 2; PT Assistant – 7; Purchasing Agent – 1; Quality Risk coordinator – 1; Receipting Clerk – 1; Receptionist – 12; RN – 36; Registration Clerk – 12; Registration Supervisor – 1; Respiratory Therapy manager – 1; RN Infection Control – 1; RT Tech – 5; SCILAHEC Director – 1; Senior Accountant – 1; Senior Life Manager (RN) – 1; Shuttle Driver – 4; Social Service Aide – 1; Speech Pathology Coordinator – 1; Surgeon – 1; Surgery Manager (RN) – 1; Surgical Tech – 2; Therapist/Counselor – 2; Therapy Director – 1; Transcriptionist – 4; Transitional Care Coordinator – 1; Ultrasound Tech – 2; Wellness Operations Manager – 1; Wellness Screener – 3.

Zip Codes of Employees Residence:

33849, 62214, 62233, 62237, 62238, 62257, 62263, 62268, 62271, 62272, 62274, 62278, 62286, 62288, 62298, 62568, 62668, 62808, 62822, 62825, 62831, 62832, 62859, 62864, 62883, 62884, 62888, 62896, 62901, 62907, 62916, 62918, 62924, 62948, 62951, 62966, 62994, 62997, 62999

Benchmarks for the continued maintenance and improvement of these job levels:

Benchmarks for the continued maintenance and improvement of these job levels across CAHs includes the following activities: Annual salary reviews; annual trainings, including trainings for all staff and specific job-level trainings; annual FTE review; education training and skillset training with patients and equipment; salary surveys (hospital specific and ICAHN); QHR productivity; ICAHN list serve; productivity goals; job performance evaluations, including self-evaluations and supervisor evaluations; exit interviews; and reviewing comparative regional salary survey to verify the salaries provided are within market and staying competitive.

2. Please estimate the number of new employees that will be hired over the duration of your proposal.

- 18 CHWs
- 9 APRNs/LCSWs
- 1 Project Director
- 1 Equity Coordinator

3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

For the Delta REACH project, a number of new employment opportunities will be necessary including hiring the Project Director, the 18 CHW positions (2 per hospital – one part time and one full time), 9 APRNs (or LCSWs), and one Equity Coordinator.

It is imperative to the success of the project that the CHW positions are filled by individuals that are "of the community." Community-based organizations, health care systems, and payers are increasingly supporting staff whose most powerful credentials are their own personal knowledge and experiences. Community Health Workers have close ties to the communities where they both live and work, along with the experiences that they share with the people they serve. By leveraging their personal experiences and ties to their communities, this workforce is recognized for its unique ability to forge trusting relationships, thus making them invaluable for engaging a wide range of populations and building critical connections between health care systems and communities.

A CHW's role depends on factors such their education, training, lived experience, and experience working with specific populations. CHWs may perform the following roles:

- Create connections between vulnerable populations and healthcare providers
- Help patients navigate healthcare and social service systems
- Manage care and care transitions for vulnerable populations
- Reduce social isolation among patients
- Determine eligibility and enroll individuals in health insurance plans
- Ensure cultural competence among healthcare providers serving vulnerable populations
- Educate healthcare providers and stakeholders about community health needs
- Provide culturally appropriate health education on topics related to chronic disease prevention, physical activity, and nutrition
- Advocate for underserved individuals or communities to receive services and resources to address health needs
- Collect data and relay information to stakeholders to inform programs and policies
- Provide informal counseling, health screenings, and referrals
- Build community capacity to address health issues
- Address social determinants of health

The DRCCC Steering Committee will work closely with each CAH and its respective Community Advisory Board to hire CHWs that not only live in the community, but also represent the racial/ethnic diversity of that community served. This will support the element of trust necessary for the CHWs to connect with patients in a meaningful way and ensure that the

CHWs have knowledge of the resources and support services existing in the community for addressing social determinants of health.

4. Please describe any planned activities for workforce development in the project.

As stated previously, the Delta REACH project will include the hiring of additional staff to support project implementation and the proposed intervention, who are primarily focused on implementing care coordination through the use of Community Health Workers (CHWs). A key component to ensuring each CAH has qualified, knowledgeable CHWs is providing targeted training opportunities upon hire and ongoing as the project continues. Training of the CHWs will be provided by the Illinois Public Health Association (IPHA). The IPHA currently provides CHW training across the state and has tested, evidence-based training programs that includes training in 12 core competencies including: 1) Advocacy, 2) Communications, 3) Presentation & Facilitation Skills, 4) Organizational Skills, 5) Cultural Competency/Humility, 6) Interpersonal and Relationship Building Skills, 7) Knowledge of major health body systems, 8) Behavioral Health, 9) Public Health, 10) Field Experience, 11) Service Coordination and Navigation Skills, and 12) Trauma Informed Care.

Each CHW joining the Delta REACH project will complete an initial training, which includes a 40-hour curriculum, 12 weeks of case model learning during field experience, 1 year of wellness and technical assistance support, and access to ongoing training opportunities. After the first year, the CHWs will continue to receive wellness, technical assistance and ongoing training opportunities. Additionally, IPHA will provide ongoing consultation services to the CAHs that will be integrating CHWs into their facilities. Up to 15 hours per month will be provided to the CAHs to address system integration and supervisory challenges. This consultation service will also include a quarterly site visit to each CAH facility.

In addition to the training provided by IPHA, the to-be-hired Equity Coordinator will provide ongoing training/learning opportunities for the DRCCC members and their staff, ensuring that each entity is intentionally focused on improving the equity and diversity of their staff, patients/clients, and partners.

The COVID-19 pandemic has had numerous negative impacts on healthcare and the healthcare workforce, including significant healthcare professional shortages. It is important to ICAHN and the DRCCC members that the staff hired to support the project are given tools and resources to help them be resilient and cope with the day-to-day challenges they will face, primarily due to the pandemic. ICAHN will provide resiliency and burn-out prevention resources and support to staff at the CAHs, including the staff hired for this project. These tools and resources may include training opportunities, wellness activities, peer support opportunities (e.g., social media, listserv), mental health support services and resources, etc. The APRNs may also play a role in ensuring the resiliency and retention of the CHWs at their CAH through open dialogue and resource sharing.

Form 13: Quality Metrics

1. Tell us how your proposal aligns with the pillars and overall vision for improvement in the Department's quality Strategy

Delta REACH aligns to four HFS Quality Pillars:

I. Adult Behavioral Health: Research shows that ED visits for behavioral/mental health and/or SUD/OUD are increasing among Medicaid patients; this is certainly the experience of the 9 CAHs. Utilizing the SBIRT alongside the CMS SDOH screening tool will enable CHW/APRN Care Teams to identify patients in need of behavioral/mental health care and/or SUD/OUD treatment. Moreover, Delta REACH is anchored in an understanding that many individuals struggling with behavioral/mental health issues and/or SUD/OUD have a nexus of SDOH needs that must be addressed before healthcare can help. Through the CHWs' care coordination and leveraging of the technology platform to track patients' access to necessary healthcare and SDOH support, Delta REACH's goals closely align with the HFS Quality Strategy goal of "Improve Behavioral Health Services and Supports for Adults," particularly through improving "integration of physical and behavioral health," and "improving care coordination and access to care for individuals with alcohol and/or substance use disorders."

II. Child Behavioral Health: Medicaid-insured children often visit the ED at higher rates than privately insured children, due to higher burdens of certain chronic conditions and lower access to primary care[40]; this is again experienced acutely by the 9 CAHs. Delta REACH's goals align closely with the HFS Quality Strategy goal of "Improve Behavioral Health Services and Supports for Adults," particularly through "improving integration of physical and behavioral health," and "reducing avoidable psychiatric hospitalizations through improved access to community-based services." The CHW/APRN Care Team model ensures that children experiencing behavioral/mental health issues or at risk for them will be identified, their situations assessed, and a plan of resolution created.

IV. Equity: Delta REACH will address key health disparities in diseases, chronic conditions, and COVID-19. The project will enable the 9 CAHs to significantly improve their engagement of Medicaid-eligible individuals in preventative care, such as increased screenings and well visits. The ongoing work of a full-time Equity Coordinator to ensure the input of diverse voices in all key project strategies and to deliver the first regional approach to cultural competency education ensures the continued elevation of equity in regional conversation and social reform efforts. Moreover, the critical involvement of NAACP and IMC as members of the DRCCC reflects HFS's focus on "incorporating enterprises that are culturally competent with the capability of mitigating challenges across the continuum of healthcare, including the social and structural determinants of health."

V. Community-based Services and Supports: ED providers and staff of the 9 CAHs are well-aware that the "frequent flyers" they see in the ED do not arrive solely on the basis of medical conditions. With significantly higher rates of poverty as compared to the state and nation, the IDR is home to many individuals who struggle to meet their basic needs. Although a multitude of community-based organizations exist to address food, housing,

---

[40] Recurrent and high-frequency use of the emergency department by pediatric patients. Alpern ER, Clark AE, Alessandrini EA, Gorelick MH, Kittick M, Stanley RM, Dean JM, Teach SJ, Chamberlain JM, Pediatric Emergency Care Applied Research Network (PECARN). Acad Emerg Med. 2014 Apr; 21(4):365-73.

employment, and transportation needs, vulnerable populations struggle to access them. Delta REACH's key strategies will form the "missing link" between these individuals and community-based services and support. Through the CHW model, the project closely aligns with HFS's Healthy People, Healthy Communities strategy to "implement evidence-based interventions to reduce disparities." In short, Delta REACH will allow individuals to receive more needed care, more quickly, within the health system and within their communities.

In accordance with this alignment, DRCCC will track metrics required by HFS. We also propose additional, separate metrics for monitoring and tracking; these are indicated in the response to question #3 below. Please note that although we are not proposing to formally track data for the Maternal and Child Health Quality Pillar, this pillar will nevertheless be part of the Needs Assessment and Gap Analysis, and will be included in Steering Committee discussions around access to care. Should DRCCC decide to formally incorporate the Maternal and Child Health Quality Pillar into the project, DRCCC will collaborate with HFS to add quality metrics to its reporting matrix.

As described previously, DRCCC will focus on reporting metrics for the pillars of Adult Behavioral Health and Child Behavioral Health during Years 1 and 2, and will expand to reporting metrics for Equity and Community-based Services and Support for Years 3-5. This approach reflects a pragmatic understanding of the capacity of rural CAHs to adopt new workflows and data collection methods, especially following a public health emergency. This gradual approach ensures fidelity to rigorous data collection and data reporting processes. As the evaluator, SIU will create a data model in tandem with its evaluation plan during Year 1. SIU will collaborate with the DRCCC Steering Committee, the CHW/APRN care teams, and the Community Advisory Boards to develop seamless data tracking processes to support evaluation.

2. Does your proposal align with any of the following Pillars of Improvement?

2a. Maternal and Child Health?

No

2b. Adult Behavioral Health?

Yes

1. % 7-Day and 30-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

2c. Child Behavioral Health?

Yes

1. % 7-Day and 30-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM)—6–17 years of age stratification

2d. Equity?

Yes

1. Breast Cancer Screening (BCS)
2. Cervical Cancer Screening (CCS)
3. Controlling High Blood Pressure (CBP)
4. Adults' Access to Preventive/Ambulatory Health Services (AAP)

2e. Community-Based Services and Supports

Yes

1. Getting Care Quickly (CAHPS measure)
2. Getting Needed Care (CAHPS measure)

3. **Will you be using any metrics not found in the quality strategy?**

Yes

1. % 7-Day and 30-Day Follow-Up After Emergency Department Visit for Mental Health
2. Avoidable hospital readmission
3. Risk-adjusted Medicaid and uninsured hospitalizations per 1,000
4. ED utilization by Medicaid patients
5. Number of closed loop referrals for SDOH by category (housing, food security, transportation)

Form 14. Milestones: *For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, and when people will be hired). The timeline should be in months from award.*

A description of time-bound milestones is included as an attachment to this form.

Strategies	**Key Activities**	**Key Personnel Responsible**	**Timeline**
1. Convene all governing bodies providing oversight and guidance to achieve project goals	**1.a.** Recruit and hire qualified Project Director **1.b.** Convene the DRCCC Steering Committee to provide oversight of all key project activities, address challenges, and oversee project progress **1.c.** Recruit and hire qualified Equity Coordinator **1.d.** Form the Needs Assessment/Gap Analysis Subcommittee (Project Director, SIU, Equity Coordinator) to execute a regional needs assessment, inventory of existing services and resources, and corresponding gap analysis **1.e.** Form the Equity Subcommittee (Equity Coordinator, NAACP, IMC, SIU) to engage diverse stakeholders across the region, ensure embedment of inclusion and equity in project activities, and develop cultural competency curriculum for provider and staff training **1.f.** Form the Alternative Payment Model Subcommittee (Project Director, CFOs from each CAH) to develop strategies for engaging HFS in the development of APMs for reimbursement of CHW services and promote sustainability	**1.a.** ICAHN CEO, Franklin Hospital (fiscal agent) CEO **1.b**. Project Director, DRCCC Steering Committee **1.c.** Project Director, DRCCC Steering Committee **1.d.** Project Director, Needs Assessment/Gap Analysis Subcommittee **1.e.** Project Director, Equity Subcommittee **1.f.** Project Director, APM Subcommittee	**1.a.** Within 60 days of notice of award **1.b.** Within the first 30 days of project period; monthly for first six months of Year 1; quarterly thereafter through Year 5 **1.c.** Within the first 60 days of project period **1.d.** Within 30 days of project period; weekly for first two months and monthly thereafter through Year 1 **1.e.** Within 90 days of project period; quarterly during Years 1-2 and monthly thereafter through Years 3-5

Strategies	Key Activities	Key Personnel Responsible	Timeline
2. Conduct Needs Assessment and Gap Analysis	**2.a.** Establish baseline data for relevant core measures, such as ED utilization, hospitalization, transfer, and discharge rates; and primary care, specialty care, behavioral health, and SUD/OUD treatment referral rates. 2.b. Conduct inventory of existing health care providers and services as well as community-based services, supports, and resources addressing SDOH will be conducted. 2.c. Perform gap analysis to analyze existing referral patterns and identify gaps in services.	**2.a-c.** Needs Assessment/Gap Analysis Subcommittee	**2.a-b.** Within four months of Year 1 **2.c.** Within six months of Year 1
3. Develop technology platform to animate the patient referral process between CHWs and providers/CBOs and to systematize data tracking and collection efforts	**3.a.** Engage HFS in identifying potential partnerships with existing technology contracts, such as Collective Medical, to create the platform **3.b.** Identify additional potential contract opportunities for the platform build **3.c.** Finalize contract with HFS or other entity for platform build **3.d.** Technology platform built **3.e.** Technology platform implemented at 4 CAHs for Phase 1 Implementation **3.f.** Technology platform implemented at 5 CAHs for Phase 2 Implementation	**3.a-c.** ICAHN CEO, Project Director, DRCCC Steering Committee **3.d.** IT lead at HFS or another contracted IT firm **3.e-f.** Project Director, IT lead for HFS or another contracted IT firm, IT lead at each CAH	**3.a.** Within 30 days of project period **3.b.** Within 45 days of project period **3.c.** Within 90 days of project period **3.d.** Within first 7 months of Year 1 **3.e.** By the end of Year 1 **3.f.** Within the first 6 months of Year 2
4. *Phase 1:* Implement the CHW model in 4 initial CAHs -Franklin Hospital -Ferrell Hospital -Memorial Hospital	**4.a.** Recruit and hire 1.4FTE CHWs for each CAH (4 x 1.0FTE, 4 x 0.4FTE) **4.b.** Recruit and hire 4 1.0 FTE APRNs for each CAH **4.c.** Provide comprehensive CHW training via a standardized, evidence-based curriculum	**4.a-b.** Project Director, DRCCC Steering Committee **4.c.** Illinois Public Health Association **4.d.** Project Director, ICAHN CEO,	**4.a.** Within first three months of Year 1 **4.b.** Within first nine months of Year 1 **4.c.** Within the first 9 months of Year 1 **4.d.** By the end of Year 1

Strategies	Key Activities	Key Personnel Responsible	Timeline
-Sparta Community Hospital	**4.d.** Provide APRN cultural competency and trauma-informed care training via established webinar series **4.e.** Onboard each of 4 CHW/APRN care teams at 4 CAHs	ICAHN Professional Education team **4.e.** Project Director, DRCCC Steering Committee	**4.e.** By the end of Year 1
5. *Phase 2*: Implement the CHW model in 5 additional CAHs -Hamilton Memorial -Marshall Browning Hospital -Massac Memorial Hospital -Pinckneyville Community Hospital -Wabash General Hospital	**5.a.** Recruit and hire 1.4FTE CHWs for each additional CAH (5 x 1.0FTE, 5 x 0.4FTE) **5.b.** Recruit and hire 5 1.0 FTE APRNs for each CAH **5.c.** Provide comprehensive CHW training via a standardized, evidence-based curriculum **5.d.** Provide APRN cultural competency and trauma-informed care training via established webinar series **5.e.** Onboard each of 5 CHW/APRN care teams at 5 CAHs	**5.a-b.** Project Director, DRCCC Steering Committee **5.c.** Illinois Public Health Association **5.d.** Project Director, ICAHN CEO, ICAHN Professional Education team **5.e.** Project Director, DRCCC Steering Committee	**5.a.** By the end of Year 1 **5.b.** Within the first three months of Year 2 **5.c.** Within the first three months of Year 2 **5.d.** Within the first six months of Year 2 **5.e.** Within the first six months of Year 2
6. Create a regional approach to health equity	**6.a.** Engage diverse stakeholders through one-on-one conversations, surveys, and focus groups to solicit ongoing input on the design and impact of key project activities **6.b.** Collaborate with NAACP Executive (Equity Subject Matter Expert for the project) to create an equity and inclusion- informed cultural competency training curriculum **6.c.** Provide standardized cultural competency education to CAH providers and staff through a	**6.a.** Equity Coordinator, Equity Subcommittee **6.b**. Equity Coordinator, Equity Subject Matter Expert, Equity Subcommittee	**6.a.** Conversations, surveys, and focus groups will be implemented beginning within the first three months of Year 1 and ongoing through Year 5; related metrics will be tracked through evaluation plan **6.b.** Within first nine months of Year 1 **6.c.** *Phase 1:* training provided to ED

Strategies	Key Activities	Key Personnel Responsible	Timeline
	phased approach (Phase 1 implementation of CHW model) **6.d.** Provide standardized cultural competency education to CAH providers and staff through a phased approach (Phase 2 implementation of CHW model)	**6.c-d**. Equity Coordinator	providers/staff at each of 4 initial CAHs by the end of month 1 of Year 2; training provided to inpatient providers/staff at each of 4 initial CAHs by the end of month 3 of Year 2 **6.d.** *Phase 2*: training provided to ED providers/staff at each of 5 CAHs by the end of month 6 of Year 2; training provided to inpatient providers/staff at each of 4 initial CAHs by the end of month 9 of Year 2
7. Increase patient access to telehealth services	**7.a.** Create workflows for each CHW/APRN team that enable access to technology for patient telehealth appointments **7.b.** Coordinate with CBOs that support access to broadband internet **7.c.** Coordinate with local technology companies offering free or discounted technology and/or broadband internet access programs **7.d.** Embed telehealth as a focus area for sustainability planning	**7.a.** DRCCC Steering Committee, CAH ED providers and staff **7.b-c**. Project Director, CHW/APRN care teams **7.d.** DRCCC Steering Committee, APM Subcommittee	**7.a.** Within first 9 months of Year 1 **7.b-c.** By the end of Year 1 for Phase 1 of CHW model; within the first six months of Year 2 for Phase 2 of the CHW model; ongoing as part of the job descriptions for CHWs/APRNs **7.d.** Telehealth embedded in sustainability plan, finalized within the first six months of Year 5

Strategies	Key Activities	Key Personnel Responsible	Timeline
8. Collaborate with payers to develop alternative payment models (APMs) and pilot payment models	**8.a.** Leverage project results/measurable outcomes to further ICAHN's working relationship with Illinois Association of Medicaid Health Plans (IAMHP) **8.b.** Propose APM for reimbursing CHW services to IAMHP **8.c.** Disseminate project results/measurable outcomes to leading managed care organizations **8.d.** Propose pilot payment model for reimbursing CHW services to at least 2-3 MCOs	**8.a.** ICAHN CEO, Project Director **8.b.** Project Director, DRCCC Steering Committee, APM Subcommittee **8.c.** ICAHN CEO, Project Director **8.d.** Project Director, DRCCC Steering Committee, APM Subcommittee	**8.a.** By the end of Year 3 **8.b.** By the end of Year 4 **8.c.** By the end of Year 4 **8.d.** Within the first three months of Year 5

Form 15: Budget

Number of Individuals Served each year:

Year 1: 100 individuals/month x 3 months x 4 hospitals = 1,200

Year 2-5: 100 individuals/month x 12 months x 9 hospitals = 10,800/year

Alternative Payment Methodologies:

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs. Upload any documentation or visuals you wish to submit in support of your response (combine into a single document for upload)

A strong CHW workforce needs sustainable funding sources that it can rely on year after year. There are ways that CHWs can tap into the health care financing system to access sustainable financing for their services through public and private payers. These strategies can be used with fee-for-service, pay-for-performance, bundled payment, global payments, and statewide assessments, as well as alternative payment models currently under consideration.

The DRCCC aims to consider a hybrid payment model for sustainability taking into account the hospitals' value-based payment model, the community-based, third-party billing model, the FQHC bundled-rate payment model, and the new proposed accreditation and payment model for CHWs. Capturing existing payment models such as the chronic disease care management model (CDCM), the per member per month (PMPM) model, the 1815 waivers model and others, the DRCCC will develop a hybrid payment model to support long-term sustainability. The DRCCC will learn from the successes of partners and engage rather than compete with each other to transform the current payment model system.

ICAHN and the DRCCC will pursue alternative payment methods to support project activities, which is led by a subcommittee of the Steering Committee. Initially, it will be important to determine the billing services related to the project (behavioral health, mental health, substance use disorder services, etc.) and define those services that cannot currently be reimbursed but would align with possible alternative payment models. ICAHN plans to explore Medicaid Integrated Home funds as well as care coordination fees from MCOs.

Additionally, over the five-year period, the DRCCC would like to explore alternative payment methods (APMs) from the State supporting CHW activities including care coordination and population health management. To do so, the collaborative proposes to partner with HFS to change how public funds are distributed using the DRCCC as a demonstration project. During the five-year project period, the DRCCC would like partner with the State and HFS to begin to create APM offsets for HTC funds as a demonstration project, so that sufficient momentum exists by the end of year 5 to transition fully to APM-based payment models that will provide ongoing project implementation.

Form 16: Sustainability *Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time. (i.e. how will your project continue to operate without HTC funding?) In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources). In your narrative, highlight any key assumptions that are critical to making your project sustainable. Provide your narrative here:*

DRCCC has designed the project with a view toward achieving long-term sustainability beyond the grant period. The project budget includes costs contained within the scope of the project period (development and launch of the technology platform; evaluation team) and costs that will be ongoing (CHW/APRN salaries/benefits; time commitment of involved CAH and CBO staff). With regard to the latter, DRCCC will pursue the following approaches toward sustainability for services addressing social determinants of health (i.e., CHWs):

1. Alternative Payment Models (APMs): As mentioned in Form 15: Budget, DRCCC plans to explore APMs supporting CHW activities, including care coordination and population health management. This would require partnering with HFS to change distribution of funds, using the DRCCC as a demonstration project, with the goal of transitioning fully to APM-based payment models by the end of Year 5. DRCCC has researched the sustainability strategies of other rural CHW models and found successful examples of sustainability through APMs. The Community Health Worker-based Chronic Care Management Program in rural Appalachia began as a pilot project in a single West Virginia county and further scaled for implementation in a multi-center, 3-state area of Appalachia. The project demonstrated such impressive results in improved health outcomes and decreased healthcare costs that its leadership was able to work with both public and private payers to develop pilot payment models/APMs to sustain the project beyond grant funding.[41]

2. New revenue streams from reduced costs of care: DRCCC CAH partners expect that successful implementation of the CHW model will not only increase access to and improve the quality of care available to some of the most vulnerable of their patient populations, but will also eventually lead to reduced costs and increased revenue. By reducing ED utilization, expanding patient panels for PCPs/specialists, and achieving quality of care metrics resulting in increased ACO incentive payments, the project has strong potential to increase revenue. This funding opportunity will therefore provide CAHs with the ability to demonstrate the positive financial and clinical impacts of improving culturally-competent, CHW-led care coordination to underserved populations, thereby bolstering the likelihood of CAH executive leadership to continue to support the project and to absorb its costs.

3. Advocacy for policy and system change: Through this funding opportunity, DRCCC will establish an APM Subcommittee for the DRCCC Steering Committee, thereby creating a

[41] Crespo, R., Christiansen, M., Tieman, K., Wittberg, R. 2020. An Emerging Model for Community Health Worker-Based Chronic Care Management for Patients With High Health Care Costs in Rural Appalachia. *Prev Chronic Dis.* 17, E13.

high-level association of diverse regional stakeholders advocating for policy and system changes affecting the CHW workforce and are critical to sustaining the services that CHWs provide. DRCCC anticipates that project evaluation will demonstrate the effectiveness of CHWs and the cost saving associated with employing them, thus providing critical evidence about the effectiveness of CHWs and the cost savings associated with employing these workers. DRCCC will leverage its existing strong working relationship with the Illinois Association of Medicaid Health Plans to engage HFS and disseminate project results to policymakers with the goal of advocating for reimbursement for CHW services.

Sustainability planning will be a key responsibility of the DRCCC Steering Committee and will have priority status as an agenda item beginning in Year 2. A Sustainability Plan with specific action items for DRCCC partners will be drafted within the first nine months of Year 4, and finalized within the first six months of Year 5.

Links to Hospital Community Health Needs Assessments:

Marshall Browning Hospital:
http://www.marshallbrowninghospital.com/getpage.php?name=chna

Wabash General Hospital:
https://www.wabashgeneral.com/About-Us/Community-Health-Needs-Assessment

Memorial Hospital:
https://c3a60efa-d8c8-4c3a-b61d-b7df7cea5ecb.filesusr.com/ugd/92efe2_2c7a07b7935849538e3813b3802a7710.pdf

Ferrell Hospital:
https://www.ferrellhosp.org/About-Us/Documents-About-us/HOME-PAGE-LINK-Community-Health-Needs-Assessment-7

Hamilton Memorial Hospital:
https://www.hmhospital.org/wp-content/uploads/2015/10/Hamilton-Memorial-Hospital-CHNA-FINAL.pdf

Table 1. Socioeconomic/poverty indicators

	Population without health insurance	Median household income	People living in poverty	Children living in poverty	% Caucasian living in poverty	% African American living in poverty	% Two or more races living in poverty	% Hispanic/ Latino living in poverty
Edwards	6.2	51,080	10.2	11.4	9.9	33.3	23.3	25.8
Franklin	6.3	42,769	19.5	25.2	19.0	33.5	28.5	41.7
Hamilton	5.4	54,046	9.3	8.5	9.2	61.5	n/a	0.0
Jackson	6.4	37,241	26.5	29.2	20.4	49.6	40.2	38.3
Lawrence	7.6	46,636	16.2	24.4	15.6	14.3	7.2	38.7
Massac	5.4	47,481	16.7	20.2	16.0	24.8	22.4	51.9
Perry	3.9	52,428	16.1	24.2	15.9	31.7	20.1	29.9
Pope	4.0	38,056	15.3	17.4	15.9	14.3	n/a	15.4
Randolph	5.2	53,816	12.7	19.5	12.0	17.7	22.2	34.9
Saline	4.2	44,090	21.1	29.2	20.5	30.4	35.9	9.2
Wabash	7.1	50,770	12.0	11.9	12.5	6.3	0.4	0.3
White	4.8	49,290	14.0	19.5	13.7	69.6	28.2	25.0
Illinois	6.8	65,886	12.5	17.1	9.4	26.1	16.0	16.1
United States	8.8	62,843	13.4	18.5	11.1	23.0	16.7	19.6

Source: U.S. Census Bureau, American Community Survey. 2019: 5 year estimates

Table 2. Socioeconomic and Physical Environment Indicators

	Food Insecurity	Limited Access to Healthy Foods	Children Eligible for Free or Reduced Lunch	Unemployment	Severe Housing Problems	Broadband Access
Edwards	10%	8%	38%	4.1%	7%	78%
Franklin	15%	4%	55%	5.4%	13%	73%
Hamilton	10%	4%	52%	3.9%	8%	73%
Jackson	15%	11%	71%	3.8%	20%	78%
Lawrence	14%	5%	56%	5.2%	9%	75%
Massac	15%	4%	67%	5.6%	16%	67%
Perry	13%	10%	49%	5.1%	13%	75%
Pope	14%	8%	61%	5.6%	8%	61%
Randolph	11%	3%	49%	3.7%	8%	77%
Saline	16%	20%	59%	5.3%	13%	72%
Wabash	11%	2%	53%	3.8%	10%	77%
White	12%	14%	55%	3.8%	10%	75%
Illinois	10%	4%	49%	4.0%	17%	83%
Top U.S. Performers	9%	2%	32%	2.6%	9%	86%

Source: County Health Rankings and Roadmaps, 2021

Table 3. Death rates and disease prevalence

	Heart Disease death rate	Stroke death rate	CLRD death rate	Diabetes prevalence	Obesity prevalence	Chronic Conditions among Medicare beneficiaries	
						Hypertension	Hyperlipidemia
Edwards	296.4	66.1	44.6	9.0%	30%	60.7%	37.9%
Franklin	165.6	41.5	84.9	12.5%	33%	62.2%	44.8%
Hamilton	183.7	48.4	79.6	12.0%	29%	57.3%	31.7%
Jackson	165.4	31.8	37.7	7.8%	25%	59.0%	41.9%
Lawrence	192.0	38.3	51.6	13.9%	30%	63.7%	37.6%
Massac	105.6	39.0	75.5	11.7%	35%	67.9%	52.4%
Perry	198.9	37.3	50.1	10.1%	28%	60.7%	31.6%
Pope	139.7	n/a	n/a	11.7%	26%	60.6%	39.6%
Randolph	180.8	52.5	56.2	8.2%	38%	64.6%	46.7%
Saline	228.8	42.4	80.9	14.7%	27%	59.3%	43.7%
Wabash	122.0	32.5	62.4	12.0%	28%	64.2%	28.8%
White	192.8	38.2	72.5	14.7%	29%	62.6%	41.6%
Illinois	163.1	37.9	38.5	10.2%	30%	58.1%	39.8%
United States	161.5	37.1	41.1		26%	57.1%	40.7%

Sources: Illinois State Department of Health (2019 death rates; diabetes prevalence 2018); County Health Rankings & Roadmaps 2021 (obesity prevalence); CMS County Level Chronic Conditions 2017

Table 4. Behavioral risk factors

	Smoking	Excessive Drinking	Physical Inactivity	Teen births
Edwards	15%	20%	27%	33
Franklin	18%	19%	29%	46
Hamilton	16%	19%	28%	27
Jackson	19%	19%	25%	20
Lawrence	18%	21%	26%	44
Massac	16%	18%	31%	37
Perry	16%	21%	26%	32
Pope	15%	19%	23%	29
Randolph	17%	20%	27%	32
Saline	19%	18%	36%	47
Wabash	16%	20%	22%	32
White	16%	19%	21%	48
Illinois	15%	21%	22%	21
United States	14%	13%	20%	13

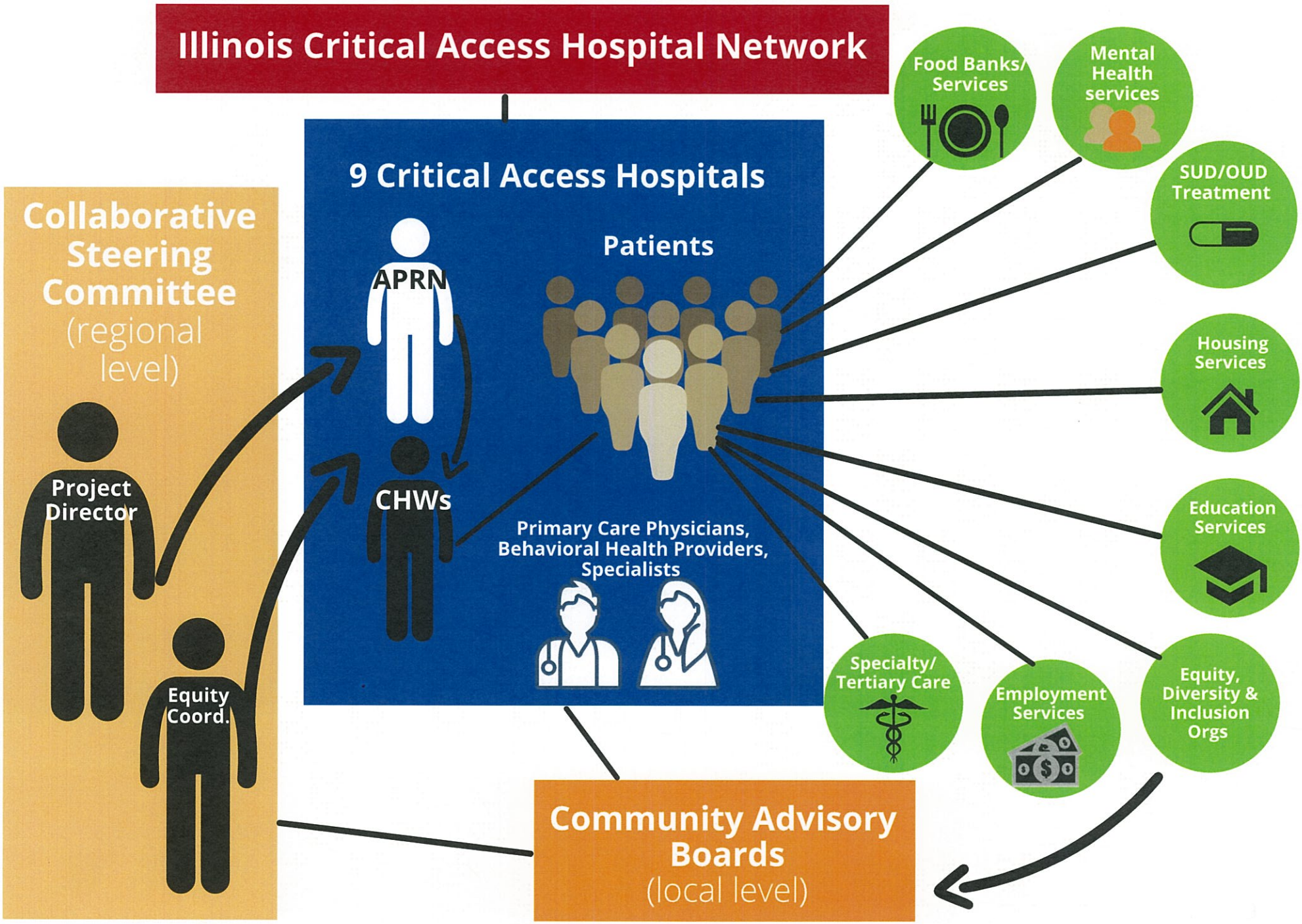
Source: County Health Rankings & Roadmaps, 2021

Table 5. Mental and behavioral health risk factors

	Suicide death rate	Drug Overdose death rate	Alcohol-impaired driving deaths	Opioid Dispensing rate	Depression among Medicare beneficiaries
Edwards	n/a	n/a	0%	46.1	10.6%
Franklin	16.0	26	26%	38.4	20.2%
Hamilton	n/a	n/a	40%	9.3	15.5%
Jackson	12.0	20	23%	106.3	20.6%
Lawrence	n/a	n/a	38%	45.8	13.8%
Massac	n/a	n/a	37%	74.3	18.9%
Perry	n/a	19.0	39%	60.9	16.9%
Pope	n/a	n/a	50%	27.5	17.0%
Randolph	n/a	11.0	29%	42.0	19.8%
Saline	31.0	n/a	21%	127.1	18.7%
Wabash	n/a	n/a	33%	33.1	13.4%
White	n/a	n/a	7%	29.4	18.7%
Illinois	10.0	22	31%	43.1	16.3%
United States	13.2	11	11%	46.7	17.9%

Sources: County Health Rankings & Roadmaps 2021 (drug overdose); CDC U.S. Opioid Dispensing Rate Maps 2019; CMS County Level Chronic Conditions 2017

DELTA REGION CARE COORDINATION COLLABORATIVE



COLLABORATIVE PARTNER MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (MOU) intends to express the intention of the signatories to cooperate as a consortium as defined herein among the following participants:

1. Illinois Critical Access Hospital Network (ICAHN)
2. Ferrell Hospital
3. Franklin Hospital District
4. Hamilton Memorial Hospital District
5. Marshall Browning Hospital Association
6. Massac Memorial Hospital
7. Memorial Hospital
8. Pinckneyville Community Hospital
9. Sparta Community Hospital District
10. Wabash General Hospital District

The parties specified above understand the collaborative is to implement the Delta Region Care Coordination Collaborative (DRCCC), funded by the Illinois Department of Healthcare and Family Services (IL HFS) Healthcare Transformation Collaboratives program, with the Illinois Critical Access Hospital Network (ICAHN) as the lead applicant. The above-mentioned parties recognize the mutual commitment, understanding and benefits of the relationship that exists between ICAHN and the IL HFS. The parties recognize and pledge their commitment to the DRCCC for the funding period of five years, beginning upon signature of a funding agreement between ICAHN and IL HFS, towards reaching the goals set forth in the HTC application.

The overarching goal of this project is to holistically increase access to care, address social determinants of health, and improve health equity for rural Medicaid-eligible patients in the Southern Illinois Delta Region. This will be accomplished by 1) creating a dynamic, culturally competent care coordination infrastructure at the local and regional levels that increases access to quality care, improves health outcomes, and reduces cost of care for rural Medicaid-eligible patients; 2) developing a technology platform that both animates and evaluates this care coordination infrastructure at the local and regional level, as well as supports standardized collection and sharing of population health data; 3) demonstrating the effectiveness of CHWs in increasing access to care, improving health outcomes, and reducing costs by conducting comprehensive process and outcome evaluation; 4) improving health equity through a regional approach to cultural competency training for healthcare providers and staff; and 5) advancing

advocacy for policy reform that would incorporate CHWs into billable services by exploring collaboration with payers to develop pilot payment models.

As the lead applicant, ICAHN intends to contribute to this goal by:

- Serving as the lead applicant providing administrative direction, budgetary oversight, logistical support and reporting responsibility for the Collaborative and project.
- Overseeing compliance with all grant requirements, including reporting to the IL HFS.
- Hiring and housing key personnel, including the Project Director.

All Collaborative Members intend to contribute to this goal by:

- Hiring a Community Health Worker (CHW) to provide project implementation activities, including care coordination of Medicaid patients
- Assigning key leadership to represent their hospital on the collaborative's Steering Committee.
- Participating equally and actively in the execution of project activities and in the monitoring and analysis of progress toward goals.
- Willing to receive funding to cover the community health worker program and other DRCCC initiatives as determined by the budget.
- Communicate regularly with ICAHN and the project's key personnel to ensure accountability regarding project responsibilities and roles.
- Collaborating with members to develop and strengthen the DRCCC.
- Participating in all core activities of the project including:
    - The completion of a needs assessment and gap analysis focusing on establishing baseline data for relevant core measures
    - Implementing the CHW coordinated care model, by embedding a CHW in each CAH's emergency department
    - Supporting the development of a technology platform to support tracking key project metrics spanning healthcare and social determinants of health indicators
    - Actively engaging its providers and staff in enhanced cultural competency training

Obligations

This MOU does not establish obligations or assumption of liabilities by any Collaborative Member. Each Collaborative Member acknowledges that this MOU, as a voluntary expression of mutual intention, does not affect the extent to which each Collaborative Member bears liability arising out of its own actions or inactions, whether in the context of the project or otherwise.

Conflict of Interest

Each Collaborative Member acknowledges to the other Collaborative Members that, to the best of its knowledge, no conflict of interest exists, which is likely to affect its involvement in the Collaborative or its performance of activities related to this MOU.

Amendment
This agreement may be amended by mutual consent of all parties.

Statement of Understanding
By signing below, the Collaborative Member acknowledges (a) that they have received a copy of this Agreement, (b) that they have read the Agreement carefully before signing it, (c) that they understand and agree to contribute to the goals listed above.

Each Collaborative Member representative is to submit this signed Agreement electronically to Pat Schou, ICAHN CEO at pschou@icahn.org or in its original form to 1945 Van's Way Princeton, IL 61356.

Patricia Schou - CEO
Illinois Critical Access Hospital Network

11-17-2021
Date

Alisa Coleman CEO
Ferrell Hospital Community Foundation

11.17.21
Date

Jim Johnson – CEO
Franklin Hospital District

11/15/2021
Date

Victoria Woodrow - CEO
Hamilton Memorial Hospital District

11-15-2021
Date

Larry Spour - COO
Marshall Browning Hospital Association

11-15-2021
Date

Lennis Thompson - CEO
Massac Memorial Hospital

11.15.2021
Date

Brett Bollman - CEO
Randolph Hospital District/d/b/a Memorial Hospital

11/15/2021
Date

Randall W. Dauby - CEO
Pinckneyville Community Hospital

11/15/2021
Date

Joann Enge - CEO
Sparta Community Hospital District

11.15.2021
Date

Karissa Turner - CEO
Wabash General Hospital District

11/15/21
Date

Illinois Public Health Association

500 West Monroe, Suite 1E, Springfield, Illinois 62704
Phone: 217-522-5687 FAX: 217-522-5689 E-mail: ipha@ipha.com Web Site: www.ipha.com

November 12, 2021

Pat Schou, Executive Director
Illinois Critical Access Hospital Network (ICAHN)
1945 Van's Way
Princeton, IL 61356

Re: Healthcare Transformation Collaborative Round 2 Application

Dear Ms. Schou:

The Illinois Public Health Association is pleased to support and commit to your application for funding from the *Healthcare Transformation Collaboratives* program through the Illinois Department of Healthcare and Family Services. IPHA is the oldest and largest public health association in the State of Illinois. As one of the largest affiliates of the American Public Health Association, IPHA is widely recognized as a leader in the field of public health advocacy, health education and promotion.

We are committed to partnering with ICAHN and the other members of the Delta Region Care Coordination Collaborative (DRCCC) to achieve the goal of holistically increasing access to care, addressing social determinants of health, and improving health equity for rural Medicaid-eligible patients in the Southern Illinois Delta Region.

To ensure the success of the DRCCC, Illinois Public Health Association specifically commits to providing the following activities, resources and/or support to ensure the project's success:

- Participation in the DRCCC, including providing input and support to the DRCCC Steering Committee, as needed and applicable
- Providing training support to ICAHN for Community Health Workers hired as part of the HTC project
- Conduct evaluation and reporting activities, including data collection tied to process and outcome measures, specific to the services and support we will provide; provide this data to the Program Manager; consult with the Evaluation Team as necessary
- Collaborate with the DRCCC to develop strategies for long-term sustainability

The DRCCC is extremely important and critical to improving the health of our community, enhancing the quality of care we can provide, and decreasing healthcare costs for residents in the Delta region of southern Illinois. We are excited to be a collaborative partner and to do our part to address social determinants of health in our community. If I can provide any additional information to support the application to the Healthcare Transformation Collaboratives program, please let me know.

Sincerely,

Tom Hughes
Executive Director

Linda Flowers, Ph.D., *President*
Carbondale Branch NAACP
P.O. Box 3303
Carbondale, IL 62902-3303
carbondalebranchnaacp@gmail.com
618/203-6252

November 17, 2021

Pat Schou, Executive Director
Illinois Critical Access Hospital Network (ICAHN)
1945 Van's Way
Princeton, IL 61356

Re: Healthcare Transformation Collaborative Round 2 Application

Dear Ms. Schou,

The Carbondale NAACP is pleased to support and commit to your application for funding from the *Healthcare Transformation Collaboratives* program through the Illinois Department of Healthcare and Family Services.

The mission of the National Association for the Advancement of Colored People is to ensure the political, educational, social, and economic equality of rights of all persons and to eliminate racial hatred and racial discrimination.

We are committed to partnering with ICAHN and the other members of the Delta Region Care Coordination Collaborative (DRCCC) to achieve the goal of holistically increasing access to care, addressing social determinants of health, and improving health equity for rural Medicaid-eligible patients in the Southern Illinois Delta Region.

To ensure the success of the DRCCC, the Carbondale NAACP specifically commits to providing the following activities, resources and/or support to ensure the project's success:

- Ongoing participation in the DRCCC, including attending Community Advisory Board meetings and providing input and support to the DRCCC Steering Committee, as needed and requested
- Provide outreach support to BIPOC populations across the region, including volunteer support
- Conduct evaluation and reporting activities, including data collection tied to process and outcome measures, specific to the services and support we will provide; provide this data to the Program Manager; consult with the Evaluation Team as necessary
- Consult with the DRCCC Equity Coordinator and Equity and Diversity Subcommittee as needed to provide advisement and support to ensure cultural competent care and coordination across the region
- Collaborate with the DRCCC to develop strategies for long-term sustainability

The DRCCC is extremely important and critical to improving the health of our community, enhancing the quality of care we can provide, and decreasing healthcare costs for residents in the Delta region of southern Illinois. We are excited to be a collaborative partner and to do our part to address social determinants of health in our community. If I can provide any additional information to support the application to the Healthcare Transformation Collaboratives program, please let me know.

Sincerely,

Linda Flowers

Linda Flowers – Executive Director

Promoting employment, education, health, housing and other opportunities.

ADMINISTRATIVE OFFICE

333 Commerce Dr. - Suite 800, Crystal Lake, Illinois 60014 ◦ TEL(815) 943-6851 FAX (815)943-6337
WWW.illinoismigrant.org

PETER VIÑA, Board Chair MAGDALENA RIVERA, Ed.D CEO/President

BOARD:
ABEL SOLORIO, V-Chair; JOSE J. LOPEZ, Secretary; MARIELA TREVIÑO, Treasurer;
MARIO ESPINOZA; FERNANDO MOLINA; ROSEMARY BOMBELA; BRIAN FWRNANDEZ, Esq.

November 12, 2021

Pat Schou, Executive Director
Illinois Critical Access Hospital Network (ICAHN)
1945 Van's Way
Princeton, IL 61356

Re: Healthcare Transformation Collaborative Round 2 Application

Dear Ms. Schou,

Illinois Migrant Council, is pleased to support and commit to your application for funding from the Healthcare Transformation Collaboratives program through the Illinois Department of Healthcare and Family Services. The Illinois Migrant Council or "IMC" primary mission is to promote employment, education, health, housing and other opportunities for migrant/seasonal farmworkers, Immigrants, refugees and their families to achieve economic self-sufficiency and stability.

We are committed to partnering with ICAHN and the other members of the Delta Region Care Coordination Collaborative (DRCCC) to achieve the goal of holistically increasing access to care, addressing social determinants of health, and improving health equity for rural Medicaid-eligible patients in the Southern Illinois Delta Region.

To ensure the success of the DRCCC, Illinois Migrant Council, specifically commits to providing the following activities, resources and/or support to ensure the project's success:

· Ongoing participation in the DRCCC, including attending Community Advisory Board meetings and providing input and support to the DRCCC Steering Committee, as needed and requested

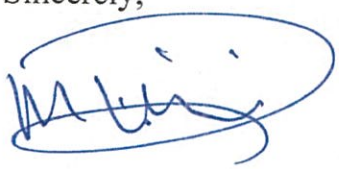
· Provide services and support to individuals referred to our services by the CHWs and Administrative Core Team at our local critical access hospital

· Conduct evaluation and reporting activities, including data collection tied to process and outcome measures, specific to the services and support we will provide; provide this data to the Program Manager; consult with the Evaluation Team as necessary

· Collaborate with the DRCCC to develop strategies for long-term sustainability

The DRCCC is extremely important and critical to improving the health of our community, enhancing the quality of care we can provide, and decreasing healthcare costs for residents in the Delta region of southern Illinois. We are excited to be a collaborative partner and to do our part to address social determinants of health in our community. If I can provide any additional information to support the application to the Healthcare Transformation Collaboratives program, please let me know.

Sincerely,



Dr. Magdalena Rivera, President/CEO IL Migrant Council

CENTERSTONE

March 26, 2021

Pat Schou, Executive Director
Illinois Critical Access Hospital Network
1945 Van's Way
Princeton, IL 61356

To Pat Schou:

I write on behalf of Centerstone in support of Illinois Critical Access Hospital Network's (ICAHN's) proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level beginning in the Delta region of southern Illinois. We strongly support this application as it meets and bridges the needs of rural residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

Centerstone is a not-for-profit health system providing mental health and substance use disorder treatments. Services are available nationally through the operation of outpatient clinics, residential programs, the use of telehealth and an inpatient hospital. Centerstone also features specialized programs for the military community, therapeutic foster care, children's services and employee assistance programs. Centerstone's Research Institute provides guidance through research and technology, leveraging the best practices for use in all our communities. Centerstone's Foundation secures philanthropic resources to support the work and mission of delivering care that changes people's lives.

Centerstone is a member/partner/participant of the following organizations/groups/coalitions:

- Benton/West City Chamber of Commerce
- Carbondale Chamber of Commerce
- Carterville Chamber of Commerce
- Du Quoin Chamber of Commerce
- Franklin-Williamson Healthy Communities Coalition
- Franklin-Williamson Positive Youth Development
- Franklin-Williamson Substance Misuse Coalition
- Healthy Southern Seven Region Coalition
- Herrin Chamber of Commerce
- Jackson County Behavioral Health Action Team
- Jackson County Healthy Communities Coalition
- Jackson County Positive Youth Development
- Madison County Mental Health Board
- Marion Chamber of Commerce
- Marion United States Penitentiary Community Relations Board
- Mental Health Alliance
- Metro East Recovery Council
- Murphysboro Chamber of Commerce
- Partnership for Drug-free Communities

CENTERSTONE

- River Bend Growth Association
- Southern Illinois Drug Awareness Conference Planning Committee
- Southeastern Illinois Community Health Coalition
- Southeastern Illinois Substance Abuse Action Team
- St. Clair County Drug Prevention Alliance
- Union County Chamber of Commerce
- West Frankfort Chamber of Commerce
- Upper Alton Business Association

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Forming a genuine partnership to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of a consortium board and/or various sub-committees.
- Participation with the consortium through advisory and/or working committees.

ICAHN will take responsibility to lead the Rural Initiative for Healthcare Transformation's activities and oversee all agreed upon deliverables.

We look forward to working with you in addressing the health and healthcare access challenges beginning in the Delta region, employing transformational interventions, and in turn, improving health outcomes eventually through the rest of the rural areas across the state.

Sincerely,

John G. Markley
Chief Executive Officer

Centerstone 200 N. Emerald Carbondale, IL 62901 Phone: 855.608.3560 Fax: 618.319.4188

ComWell
WHERE COMMUNITY MEETS WELLNESS

Phone: (618) 282-6233
www.ComWell.us
10257 State Route 3 Red Bud, IL 62278

November 12, 2021

Pat Schou, Executive Director
Illinois Critical Access Hospital Network (ICAHN)
1945 Van's Way
Princeton, IL 61356

Re: Healthcare Transformation Collaborative Round 2 Application

Dear Ms. Schou,

ComWell is pleased to support and commit to your application for funding from the *Healthcare Transformation Collaboratives* program through the Illinois Department of Healthcare and Family Services. ComWell is a Community Mental Health Center providing mental health, substance use and developmental disability services across Randolph and Washington Counties. We are committed to improving access to behavioral health services and recognize the value of addressing Social Determinants of Health and collaborative care.

We are committed to partnering with ICAHN and the other members of the Delta Region Care Coordination Collaborative (DRCCC) to achieve the goal of holistically increasing access to care, addressing social determinants of health, and improving health equity for rural Medicaid-eligible patients in the Southern Illinois Delta Region.

To ensure the success of the DRCCC, ComWell specifically commits to providing the following activities, resources and/or support to ensure the project's success:

- Ongoing participation in the DRCCC, including attending Community Advisory Board meetings and providing input and support to the DRCCC Steering Committee, as needed and requested
- Provide services and support to individuals referred to our services by the CHWs and Administrative Core Team at our local critical access hospital
- Conduct evaluation and reporting activities, including data collection tied to process and outcome measures, specific to the services and support we will provide; provide this data to the Program Manager; consult with the Evaluation Team as necessary
- Collaborate with the DRCCC to develop strategies for long-term sustainability

The DRCCC is extremely important and critical to improving the health of our community, enhancing the quality of care we can provide, and decreasing healthcare costs for residents in the Delta region of southern Illinois. We are excited to be a collaborative partner and to do

ComWell
WHERE COMMUNITY MEETS WELLNESS

Phone: (618) 282-6233
www.ComWell.us
10257 State Route 3 Red Bud, IL 62278

our part to address social determinants of health in our community. If I can provide any additional information to support the application to the Healthcare Transformation Collaboratives program, please let me know.

Sincerely,

Shea Haury, MS, LCPC
Executive Director

CENTERSTONE

March 26, 2021

Pat Schou, Executive Director
Illinois Critical Access Hospital Network
1945 Van's Way
Princeton, IL 61356

To Pat Schou:

I write on behalf of Centerstone in support of Illinois Critical Access Hospital Network's (ICAHN's) proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level beginning in the Delta region of southern Illinois. We strongly support this application as it meets and bridges the needs of rural residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

Centerstone is a not-for-profit health system providing mental health and substance use disorder treatments. Services are available nationally through the operation of outpatient clinics, residential programs, the use of telehealth and an inpatient hospital. Centerstone also features specialized programs for the military community, therapeutic foster care, children's services and employee assistance programs. Centerstone's Research Institute provides guidance through research and technology, leveraging the best practices for use in all our communities. Centerstone's Foundation secures philanthropic resources to support the work and mission of delivering care that changes people's lives.

Centerstone is a member/partner/participant of the following organizations/groups/coalitions:

- Benton/West City Chamber of Commerce
- Carbondale Chamber of Commerce
- Carterville Chamber of Commerce
- Du Quoin Chamber of Commerce
- Franklin-Williamson Healthy Communities Coalition
- Franklin-Williamson Positive Youth Development
- Franklin-Williamson Substance Misuse Coalition
- Healthy Southern Seven Region Coalition
- Herrin Chamber of Commerce
- Jackson County Behavioral Health Action Team
- Jackson County Healthy Communities Coalition
- Jackson County Positive Youth Development
- Madison County Mental Health Board
- Marion Chamber of Commerce
- Marion United States Penitentiary Community Relations Board
- Mental Health Alliance
- Metro East Recovery Council
- Murphysboro Chamber of Commerce
- Partnership for Drug-free Communities

CENTERSTONE

- River Bend Growth Association
- Southern Illinois Drug Awareness Conference Planning Committee
- Southeastern Illinois Community Health Coalition
- Southeastern Illinois Substance Abuse Action Team
- St. Clair County Drug Prevention Alliance
- Union County Chamber of Commerce
- West Frankfort Chamber of Commerce
- Upper Alton Business Association

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Forming a genuine partnership to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of a consortium board and/or various sub-committees.
- Participation with the consortium through advisory and/or working committees.

ICAHN will take responsibility to lead the Rural Initiative for Healthcare Transformation's activities and oversee all agreed upon deliverables.

We look forward to working with you in addressing the health and healthcare access challenges beginning in the Delta region, employing transformational interventions, and in turn, improving health outcomes eventually through the rest of the rural areas across the state.

Sincerely,

John G. Markley
Chief Executive Officer

Centerstone 200 N. Emerald Carbondale, IL 62901 Phone: 855.608.3560 Fax: 618.319.4188

SCH
Sparta Community Hospital

November 15, 2021

Teresa Eagleson, Director
IL. Dept. of Healthcare & Family Services
(Healthcare Transformation Initiative/Round 2)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

Sparta Community Hospital is pleased to support the application submitted by the Illinois Critical Access Hospital Network (ICAHN) and its nine Delta hospital members and their local community-based organization for funding from the *Healthcare Transformation Collaboratives* (HTC) program through the Illinois Department of Healthcare and Family Services.

The application project, Delta Region Care Coordination Collaborative (DRCCC), will establish a community support and linkage system for the nine Delta hospitals and their Medicaid beneficiaries through a community health worker (CHW) program located in their emergency departments. The CHW will serve as the bridge to link Medicaid patients with local community services and primary medical and behavioral health services as well as provide follow up review to ensure services are meeting the needs of the referred patients. The DRCCC will then enhance the process by having a central care coordination support team for all nine hospitals and lay the groundwork to add other local community, economic and social support programs to eliminate current gaps in care in following years of the project. The DRCCC overarching goal is to provide a holistically approach to the local health care process, increase access to community and primary care services, address social needs, and improve health equity for the rural Medicaid-eligible patients in the Southern Illinois Delta Region.

The nine Delta hospitals are Ferrell Hospital, Hamilton Memorial Hospital District, Wabash General Hospital, Massac Memorial Hospital, Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital District, Sparta Community Hospital District and Memorial Hospital. The DRCCC will have the ability to expand to other rural hospitals in the Delta and surrounding rural counties in following years. The DRCCC is extremely important and critical to improving the health of my community, enhancing the quality of care provided locally, and decreasing healthcare costs for residents in the Delta region of southern Illinois.

I am happy to work with the hospitals and their partner organizations to identity gaps in services and local challenged populations to improve and ensure health equity for all. Please accept my full support of this application and recognition of the tremendous needs of the rural communities served by the nine identified Delta hospitals.

Sincerely,

Joann Emge, CEO

November 16, 2021

Teresa Eagleson, Director
IL. Dept. of Healthcare & Family Services
(Healthcare Transformation Initiative/Round 2)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

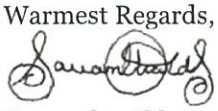
IAMHP is pleased to support the application submitted by the Illinois Critical Access Hospital Network (ICAHN) and its nine Delta hospital members and their local community- based organization for funding from the *Healthcare Transformation Collaboratives* (HTC) program through the Illinois Department of Healthcare and Family Services. As a member organization for the Medicaid managed care health plans, IAMHP works with the IL state government, legislators, advocacy groups and Medicaid patients to invest in and provide high-quality health care focused on cost-effective, individualized care that helps the residents of Illinois live longer and healthier lives.

The application project, Delta Region Care Coordination Collaborative (DRCCC), will establish a community support and linkage system for the nine Delta hospitals and their Medicaid beneficiaries through a community health worker (CHW) program located in their emergency departments. The CHW will serve as the bridge to link Medicaid patients with local community services and primary medical and behavioral health services as well as provide follow up review to ensure services are meeting the needs of the referred patients. The DRCCC will then enhance the process by having a central care coordination support team for all nine hospitals and lay the groundwork to add other local community, economic and social support programs to eliminate current gaps in care in following years of the project. The DRCCC overarching goal is to provide a holistically approach to the local health care process, increase access to community and primary care services, address social needs, and improve health equity for the rural Medicaid-eligible patients in the Southern Illinois Delta Region.

The nine Delta hospitals are Ferrell Hospital, Hamilton Memorial Hospital District, Wabash General Hospital, Massac Memorial Hospital, Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital District, Sparta Community Hospital District and Memorial Hospital. The DRCCC will have the ability to expand to other rural hospitals in the Delta and surrounding rural counties in following years. The DRCCC is extremely important and critical to improving the health of my community, enhancing the quality of care provided locally, and decreasing healthcare costs for residents in the Delta region of southern Illinois.

I am happy to work with the hospitals and their partner organizations to identity gaps in services and local challenged populations to improve and ensure health equity for all. Please accept my full support of this application and recognition of the tremendous needs of the rural communities served by the nine identified Delta hospitals.

Warmest Regards,



Samantha Olds Frey
Chief Executive Officer

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

November 16, 2021

Teresa Eagleson, Director
IL. Dept. of Healthcare & Family Services
(Healthcare Transformation Initiative/Round 2)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director, Eagleson:

The Illinois Department of Public Health (IDPH), Center for Rural Health is pleased to support the application submitted by the Illinois Critical Access Hospital Network (ICAHN) and its nine Delta hospital members and their local community- based organization for funding from the *Healthcare Transformation Collaboratives* (HTC) program through the Illinois Department of Healthcare and Family Services.

The application project, Delta Region Care Coordination Collaborative (DRCCC), will establish a community support and linkage system for the nine Delta hospitals and their Medicaid beneficiaries through a community health worker (CHW) program located in their emergency departments. The CHW will serve as the bridge to link Medicaid patients with local community services and primary medical and behavioral health services as well as provide follow up review to ensure services are meeting the needs of the referred patients. The DRCCC will then enhance the process by having a central care coordination support team for all nine hospitals and lay the groundwork to add other local community, economic and social support programs to eliminate current gaps in care in following years of the project. The DRCCC overarching goal is to provide a holistic approach to the local health care process, increase access to community and primary care services, address social needs, and improve health equity for the rural Medicaid-eligible patients in the Southern Illinois Delta Region.

The nine Delta hospitals are Ferrell Hospital, Hamilton Memorial Hospital District, Wabash General Hospital, Massac Memorial Hospital, Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital District, Sparta Community Hospital District and Memorial Hospital. The DRCCC will have the ability to expand to other rural hospitals in the Delta and surrounding rural counties in following years. The DRCCC is extremely important and critical to improving the health of these communities, enhancing the quality of care provided locally, and decreasing healthcare costs for residents in the Delta region of southern Illinois.

As partners of ICAHN for more than 20 years, IDPH is happy to work with the hospitals and their partner organizations to identity gaps in services and locally challenged populations to improve and ensure health equity for all residents. Please accept IDPH's full support of this application and recognition of the tremendous needs of the rural communities served by the nine identified Delta hospitals.

Sincerely,

Julie Casper
State Office of Rural Health Director

SIH

November 16, 2021

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Delta Region Care Coordination Collaborative, led by the Illinois Critical Access Hospital Network (ICAHN) and their proposal to the Illinois Dept. of Healthcare and Family Services (HFS) for a grant to fund transformative healthcare in our rural region of Southern Illinois. ICAHN's proposal aims to improve healthcare outcomes and reduce healthcare disparities via outreach provided by Delta region Critical Access Hospitals.

SIH is providing this letter of support as this proposed program plan can assist in meeting the needs of rural residents more holistically by linking healthcare services with community resources that address social determinants of health and chronic disease management, while reducing inequities in healthcare access and delivery. ICAHN's proposal is supportive and synergistic with Southern Illinois Healthcare's proposal for the same funding opportunity. SIH's hospitals serve as referral centers in the region and would work to coordinate care for patients in need of specialty services.

The Delta region is presented with significant challenges. These include entrenched problems such as generational poverty, racial divides and inequities, and challenges that are exacerbated by inadequate infrastructure, susceptibility to natural disasters, and lack of access to quality education, healthcare, and employment opportunities. SIH recognizes the crucial transformation that community health workers will spur, especially in rural communities, and is supportive of all work that will empower quality of and access to care for our region's patients and ultimately drive greater equity.

Thank you for your time and attention regarding this matter. Please feel free to contact me with questions or comments.

Sincerely,

Woody Thorne
Vice President, Community Affairs
and Chief Development Officer

DISTRICT OFFICE

2 NORTH VINE, 6TH FLOOR
HARRISBURG, ILLINOIS 62946
618-294-8951
618-294-8950 (FAX)

CAPITOL OFFICE

M103-F
STATE CAPITOL BUILDING
SPRINGFIELD, ILLINOIS 62706
217-782-5509
217-782-9586 (FAX)

DALE FOWLER
STATE SENATOR • 59TH DISTRICT

Teresa Eagleson, Director
IL. Dept. of Healthcare & Family Services
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson,
I am pleased to support the application submitted by the Illinois Critical Access Hospital Network (ICAHN) and its nine Delta hospital members and their local community- based organization for funding from the *Healthcare Transformation Collaboratives* (HTC) program through the Illinois Department of Healthcare and Family Services.

The application project, Delta Region Care Coordination Collaborative (DRCCC), will establish a community support and linkage system for the nine Delta hospitals and their Medicaid beneficiaries through a community health worker (CHW) program located in their emergency departments. The CHW will serve as the bridge to link Medicaid patients with local community services and primary medical and behavioral health services as well as provide follow up review to ensure services are meeting the needs of the referred patients. The DRCCC overarching goal is to provide a holistically approach to the local health care process, increase access to community and primary care services, address social needs, and improve health equity for the rural Medicaid-eligible patients in the Southern Illinois Delta Region.

The nine Delta hospitals are Ferrell Hospital, Hamilton Memorial Hospital District, Wabash General Hospital, Massac Memorial Hospital, Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital District, Sparta Community Hospital District and Memorial Hospital. The DRCCC is extremely important and critical to improving the health of my community, enhancing the quality of care provided locally, and decreasing healthcare costs for residents in the Delta region of southern Illinois.

Please accept my full support of this application and recognition of the tremendous needs of the rural communities served by the nine identified Delta hospitals.

Sincerely,

Dale Fowler, Illinois State Senator, 59th District

DISTRICT OFFICE:
600 HALFWAY ROAD, SUITE 103
MARION, ILLINOIS 62959
618.440.5090
618.440.5091 FAX
WWW.REPSEVERIN.COM

CAPITOL OFFICE:
223-N STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706
217. 782.1051
217.782.1275

DAVE SEVERIN

STATE REPRESENTATIVE · 117TH DISTRICT

November 15, 2021

Teresa Eagleson, Director
IL. Dept. of Healthcare & Family Services
(Healthcare Transformation Initiative/Round 2)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director, Eagleson:

State Representative Dave Severin, is pleased to support the application submitted by the Illinois Critical Access Hospital Network (ICAHN) and its nine Delta hospital members and their local community- based organization for funding from the *Healthcare Transformation Collaboratives* (HTC) program through the Illinois Department of Healthcare and Family Services.

The application project, Delta Region Care Coordination Collaborative (DRCCC), will establish a community support and linkage system for the nine Delta hospitals and their Medicaid beneficiaries through a community health worker (CHW) program located in their emergency departments. The CHW will serve as the bridge to link Medicaid patients with local community services and primary medical and behavioral health services as well as provide follow up review to ensure services are meeting the needs of the referred patients. The DRCCC will then enhance the process by having a central care coordination support team for all nine hospitals and lay the groundwork to add other local community, economic and social support programs to eliminate current gaps in care in following years of the project. The DRCCC overarching goal is to provide a holistic approach to the local health care process, increase access to community and primary care services, address social needs, and improve health equity for the rural Medicaid-eligible patients in the Southern Illinois Delta Region.

The nine Delta hospitals are Ferrell Hospital, Hamilton Memorial Hospital District, Wabash General Hospital, Massac Memorial Hospital, Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital District, Sparta Community Hospital District and Memorial Hospital. The DRCCC will have the ability to expand to other rural hospitals in the Delta and surrounding rural counties in following years. The DRCCC is extremely important and critical to improving the health of my community, enhancing the quality of care provided locally, and decreasing healthcare costs for residents in the Delta region of southern Illinois.

I am happy to work with the hospitals and their partner organizations to identify gaps in services and local challenged populations to improve and ensure health equity for all. Please accept my full support of this application and recognition of the tremendous needs of the rural communities served by the nine identified Delta hospitals.

Sincerely,

Dave Severin

Randolph County
WHERE ILLINOIS BEGAN!

BOARD OF COMMISSIONERS

DR. MARC L. KIEHNA, CHAIRMAN
DAVID M. HOLDER
RONALD G. WHITE

November 15, 2021

Teresa Eagleson, Director
IL. Dept. of Healthcare & Family Services
(Healthcare Transformation Initiative/Round 2)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director, Eagleson:

Randolph County is pleased to support the application submitted by the Illinois Critical Access Hospital Network (ICAHN) and its nine Delta hospital members and their local community- based organization for funding from the *Healthcare Transformation Collaboratives* (HTC) program through the Illinois Department of Healthcare and Family Services.

The application project, Delta Region Care Coordination Collaborative (DRCCC), will establish a community support and linkage system for the nine Delta hospitals and their Medicaid beneficiaries through a community health worker (CHW) program located in their emergency departments. The CHW will serve as the bridge to link Medicaid patients with local community services and primary medical and behavioral health services as well as provide follow up review to ensure services are meeting the needs of the referred patients. The DRCCC will then enhance the process by having a central care coordination support team for all nine hospitals and lay the groundwork to add other local community, economic and social support programs to eliminate current gaps in care in following years of the project. The DRCCC overarching goal is to provide a holistically approach to the local health care process, increase access to community and primary care services, address social needs, and improve health equity for the rural Medicaid-eligible patients in the Southern Illinois Delta Region.

The nine Delta hospitals are Ferrell Hospital, Hamilton Memorial Hospital District, Wabash General Hospital, Massac Memorial Hospital, Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital District, Sparta Community Hospital District and Memorial Hospital. The DRCCC will have the ability to expand to other rural hospitals in the Delta and surrounding rural counties in following years. The DRCCC is extremely important and critical to improving the health of my community, enhancing the quality of care provided locally, and decreasing healthcare costs for residents in the Delta region of southern Illinois.

#1 TAYLOR STREET • CHESTER, ILLINOIS 62233 (618) 826-5000 EXT. 226 • FAX (618) 826-3363

I am happy to work with the hospitals and their partner organizations to identity gaps in services and local challenged populations to improve and ensure health equity for all. Please accept my full support of this application and recognition of the tremendous needs of the rural communities served by the nine identified Delta hospitals.

Sincerely,

Dr. Marc L. Kiehna, Chairman
Randolph County Board of Commissioners
#1 Taylor Street
Chester, IL 62233

"The friendly little city"

City of Pinckneyville

104 South Walnut Street
Pinckneyville, Illinois 62274
(618) 357-6916

MELISSA S. KELLERMAN
City Clerk

ROBERT L. SPENCER
Mayor

November 15, 2021

Teresa Eagleson, Director
IL. Dept. of Healthcare & Family Services
(Healthcare Transformation Initiative/Round 2)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

As Mayor of the city of Pinckneyville and President of the Southern Illinois Mayors Association, I am pleased to support the application submitted by the Illinois Critical Access Hospital Network (ICAHN) and its nine Delta hospital members and their local community- based organization for funding from the Healthcare Transformation Collaboratives (HTC) program through the Illinois Department of Healthcare and Family Services.

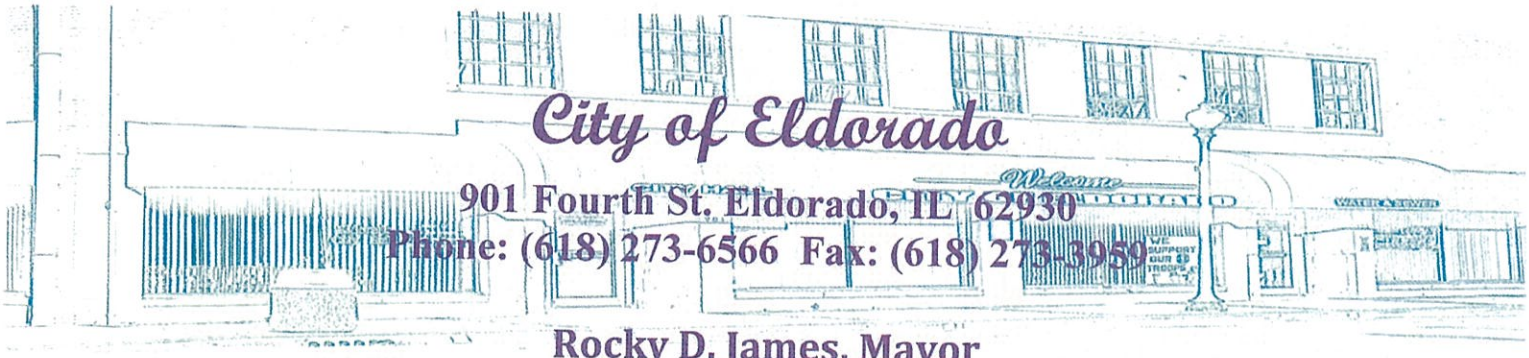
The application project, Delta Region Care Coordination Collaborative (DRCCC), will establish a community support and linkage system for the nine Delta hospitals and their Medicaid beneficiaries through a community health worker (CHW) program located in their emergency departments. The CHW will serve as the bridge to link Medicaid patients with local community services and primary medical and behavioral health services. The CHW will also provide follow up review to ensure services are meeting the needs of the referred patients. The DRCCC will then enhance the process by having a central care coordination support team for all nine hospitals which will lay the groundwork to add other local community, economic, and social support programs to eliminate current gaps in care during the following years of the project. The DRCCC's overarching goal is to provide a holistic approach to the local health care process, increase access to community and primary care services, address social needs, and improve health equity for the rural Medicaid-eligible patients in the Southern Illinois Delta Region.

The nine Delta hospitals are Ferrell Hospital, Hamilton Memorial Hospital District, Wabash General Hospital, Massac Memorial Hospital, Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital District, Sparta Community Hospital District and Memorial Hospital. The DRCCC will have the ability to expand to other rural hospitals in the Delta and surrounding rural counties in following years. The DRCCC is extremely important and critical to improving the health of my community, enhancing the quality of care provided locally, and decreasing healthcare costs for residents in the Delta region of southern Illinois.

Health equity for all is an excellent goal for southern Illinois. I am happy to work with the hospitals and their partner organizations to identity gaps in services and local challenged populations to work towards this goal. Please accept my full support of this application. I recognize tremendous needs of the rural communities served by the nine identified Delta hospitals. This project is a huge step in the right direction.

Sincerely,

Robert L. Spencer, Mayor



City of Eldorado

901 Fourth St. Eldorado, IL 62930
Phone: (618) 273-6566 Fax: (618) 273-3959

Rocky D. James, Mayor

November 15, 2021

Teresa Eagleson, Director
IL. Dept. of Healthcare & Family Services
(Healthcare Transformation Initiative/Round 2)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director, Eagleson:

Rocky James is pleased to support the application submitted by the Illinois Critical Access Hospital Network (ICAHN) and its nine Delta hospital members and their local community- based organization for funding from the *Healthcare Transformation Collaboratives* (HTC) program through the Illinois Department of Healthcare and Family Services.

The application project, Delta Region Care Coordination Collaborative (DRCCC), will establish a community support and linkage system for the nine Delta hospitals and their Medicaid beneficiaries through a community health worker (CHW) program located in their emergency departments. The CHW will serve as the bridge to link Medicaid patients with local community services and primary medical and behavioral health services as well as provide follow up review to ensure services are meeting the needs of the referred patients. The DRCCC will then enhance the process by having a central care coordination support team for all nine hospitals and lay the groundwork to add other local community, economic and social support programs to eliminate current gaps in care in following years of the project. The DRCCC overarching goal is to provide a holistically approach to the local health care process, increase access to community and primary care services, address social needs, and improve health equity for the rural Medicaid-eligible patients in the Southern Illinois Delta Region.

The nine Delta hospitals are Ferrell Hospital, Hamilton Memorial Hospital District, Wabash General Hospital, Massac Memorial Hospital, Franklin Hospital, Marshall Browning Hospital, Pinckneyville Community Hospital District, Sparta Community Hospital District and Memorial Hospital. The DRCCC will have the ability to expand to other rural hospitals in the Delta and surrounding rural counties in following years. The DRCCC is extremely important and critical to improving the health of my community, enhancing the quality of care provided locally, and decreasing healthcare costs for residents in the Delta region of southern Illinois.

I am happy to work with the hospitals and their partner organizations to identity gaps in services and local challenged populations to improve and ensure health equity for all. Please accept my full support of this application and recognition of the tremendous needs of the rural communities served by the nine identified Delta hospitals.

Sincerely,

Rocky D. James

Rocky D. James
Mayor